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This document represents the testimony given before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce of the House of Representatives on November 30, 1979. These presentations address the following areas of concern: (1) New York state services and commissions established to deal with drug abuse; (2) federal financial assistance for national and state drug abuse programs; (3) marihuana and heroin use by young adults; (4) methadone maintenance treatment programs; and (5) drug use/abuse by the elderly. Additional material submitted for the record includes articles on accidental drug addiction, sales of illegal drugs, drug treatment programs sponsored by the New York City Board of Education and the New York State Commission on Alcohol and Substance Abuse Prevention and Education, and reports of substance abuse incidents in emergency rooms and medical examiner offices. (HLM)

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THE CHANGING CHARACTER OF DRUG ABUSE: THE FEDERAL RESPONSE

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

WHERE SHOULD THE FEDERAL DRUG ABUSE POLICY BE HEADED IN THE 1980'S?

NOVEMBER 30, 1979

Serial No. 96–82

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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THE CHANGING CHARACTER OF DRUG ABUSE: THE FEDERAL RESPONSE

FRIDAY, NOVEMBER 30, 1979

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
New York, N.Y.

The subcommittee met, pursuant to notice, at 9:45 a.m., at Daytop Village, 54 West 40th Street, New York, N.Y., Hon. Henry A. Waxman, chairman, presiding.

Mr. WAXMAN. The subcommittee will come to order.

The topic of this morning's hearing is the changing character of drug abuse in America.

The abuse of alcohol and drugs continues to be one of this Nation's greatest public health threat. The economic cost to this society from substance abuse is staggering. The cost in human misery and diminished expectations is incalculable.

Over the years, the Federal Government has played an integral role in providing leadership in the drug abuse field. We have come a long way together. In the 1960's the only treatment services we had available were two public health hospitals and a small number of community clinics. Today, there are over 3,000 drug abuse treatment programs throughout the country.

I am pleased to say, the strength of our national treatment network is no where better represented than in New York City.

The subcommittee is here this morning seeking guidance. Where should Federal drug abuse policy be headed in the 1980's?

We have come late to the realization that drug abuse, even in a large metropolitan city like New York, can no longer be understood solely in terms of illicit drugs like heroin.

Data recently compiled by the Drug Enforcement Administration indicate that valium, and the use of alcohol in combination with drugs, are the leading cause of drug-related injury seen in New York City emergency rooms. The number of injuries from these substances exceed those attributed to heroin by more than 4 to 1. [See pp. 157, 167.]

These figures are a warning. They tell us that drug abuse, as many of us thought we understood it, is changing.

Increasingly we are aware of the fact that no economic, sex, age, or ethnic group in this country is immune from the threat of drug-related injury. Today the drug abuse phenomenon is characterized not only by narcotic addicts on the streets of our cities, but by teenagers combining drugs and alcohol—older Americans unknowingly misusing prescription medicines—and adult men and women

relying on mind-altering chemicals to cope with the stresses of day-to-day living.

We must continue to be vigilant to the human misery and economic injury associated with opiate abuse. We cannot afford, however, to neglect or lose sight of the very real and growing dangers posed by polydrug and alcohol abuse.

I look forward to hearing from our witnesses this morning, and gaining the benefit of their experiences and insight into this critically important area of health policy.

Before calling on our very distinguished first witness, I want to take a moment to thank Representative John Murphy, an active member of our subcommittee, and a man deeply committed to a strong Federal drug abuse policy, for his assistance in organizing today's hearing.

I also want to thank Monsignor O'Brien and the staff of Daytop Village for their hospitality and thoughtfulness in arranging and making available the facilities for this morning's hearing.

I will now call on my distinguished colleague, Congressman Murphy.

Mr. MURPHY. Thank you, Chairman Waxman.

I would like to welcome you to New York.

Henry Waxman is no stranger to New York City, albeit that he comes from the media capital, Los Angeles, and is very conversant with the particular problem that this hearing will try to lay the foundation for substantive legislative action by the Congress.

Chairman Waxman, of course, is probably the No. 1 health advocate and legislator in America. He is coming off a rather dramatic experience on hospital cost containment. He is in the lead on the major health issues in the country, particularly addressing the issue of national health insurance, and he is finishing up on a major legislative initiative on children's health plans. I am very privileged to be on the committee with him.

I am also happy that Monsignor O'Brien who is such an outstanding host, asked us to be here this morning. In 1963, Daytop was not a happy word. It started out on Staten Island, and not many people recall the total opposition of the community to any activity that was going to collectively bring together people who needed treatment. The people in the very town that were rejecting the treatment center, had children who were overdosing. Daytop probably today has as fine a handle as a community can have on drug abuse, as any community in the United States.

The abuse of drugs is indeed a problem of the most urgent importance. Reams have been written of the cost in dollars, the cost in lives, and the nonmonetary costs to society which result from the misuse of ingested and injected substances, both legal and illegal.

It is especially appropriate that this hearing is being held in New York City, which has been dubbed the drug capital of the world. I think that it may well be that, when we hear Mayor Koch's statistics and the activities of this city made necessary because of drugs, we, truly, are the drug capital of the world.

Unfortunately, Federal policy of the previous administration changed the drug emphasis and treatment programs. We went to almost a transferral program. It would seem that the White House,

at that time, felt that just a transferral, or a methadone maintenance program would be the Federal program, and we would not get into the difficulties of treating the many different psychological problems which face drug abusers.

We see that methadone has replaced heroin as the major cause of drug caused deaths, and admissions in the overdose area. Now, we can understand that the Federal policy certainly has a shortcoming, has been misguided, and does need new direction. Consequently, I am happy that we are here today.

We know that just three blocks from Federal Plaza—and we all know where Federal Plaza is—it is where the Federal Courthouse is, and is the center of criminal enforcement on the Federal level—you can buy this paraphenalia. This is a kit. You can buy these papers, which I am sure nobody uses to roll Marlboro cigarettes. I don't think that these pipes are used for Prince Albert, but they do sell a pipe cleaner with it, so that things can be properly clean for the use of cannabis and other controlled substances. Of course, the matches say, "Enjoy," and it is complete with a chain and a roach clip.

This is the freedom and ease with which this society accepts the drug culture, next to the Federal law enforcement areas of the city, and not too far from my office, I am sorry to say. I think that we should examine the entire philosophy that this society has adopted for the acceptance of these substances, and get on with a Federal program to correct it.

It strikes at our youth, and it strikes at our older people, and both of them are seemingly helpless in this society to cope with the problems. Let's hope that today we can lay a foundation for corrective action.

Mr. WAXMAN. Thank you very much.

Our first witness this morning is a former colleague of ours in the U.S. Congress, and one of the most popular mayors in the country right alongside Mayor Tom Bradley from Los Angeles.

Major Koch, we are honored to have you with us to open this hearing, and to give us some insight into what the city of New York is doing to prevent and treat the problems of drug abuse.

STATEMENT OF HON. EDWARD I. KOCH, MAYOR, NEW YORK CITY

Mayor KOCH. It is a pleasure, Mr. Chairman, to be able to testify before your committee, and before Jack Murphy, a good friend and a Member of the New York delegation.

As I have told everyone who has asked me, I miss my days in the Congress. I enjoy what I am doing now, but the friendships that were made over a 9-year period in Congress are enduring, and it is a delight to have you with us.

I would like to make a formal presentation, and then maybe to respond to questions, and also to add to that an oral statement.

As the mayor of the city of New York, I welcome this opportunity of being able to testify before you, and I am grateful that you have invited me. As you know, drug abuse is a growing problem of particular concern to those of us who live here in New York City. As Congressman Jack Murphy pointed out, we are the major urban

center, and therefore we have the major urban blight problem of narcotics.

We meet today at Daytop Village, probably one of the finest drug treatment programs in this city or anywhere else in the country. Therefore, the selection of Daytop for this hearing underscores our mutual interest in dealing with the epidemic of drug abuse among our citizens. I hasten to add that there are other fine programs for drug treatment and prevention throughout our city, but this one is particularly significant.

I was told today that one of the interesting items of information is that while they are paid on a per capita basis for 500 people—that is the full extent of their program—they actually treat 528, and they are not paid for the additional 28. They are oversubscribed.

Also I would like to just mention that on a prior occasion when I was here, Monsignor O'Brien mentioned that Pope John Paul II, who has a great interest, obviously, and compassion in the poorest of the poor who are stricken with disease, and this is a form of a disease, had offered—the offer had been accepted—the summer residence, Castel Gondolfo, for a drug addiction program, which is unique.

This problem is particularly serious in New York City. There are approximately 600,000 narcotics addicts in the United States, almost 3 out of every 10 of them, 170,000, are here in New York City. Counting the heavy and moderate chronic pill abusers, there are more than one-half million New Yorkers with a severe drug problem. Regrettably, comparable figures for the latter two categories are not available for the Nation as a whole, but we must assume that comparable figures exist for other cities.

The social and economic costs of these problems are enormous. Although the drug programs, including the city health department's methadone program, all contract with and are regulated by the State, I speak to you today as the mayor of a city which is plagued with the human and financial consequences of this problem, and I ask for the assistance that you might provide through our State agency.

New York City and State are particularly vulnerable to these costs and consequences. One reason, a geographical one, is that we are the natural port of entry for many illegal drugs. Thus we have on our hands a disproportionate share of those who abuse drugs.

Another reason is that the nature and problems of urban life, especially in a city like New York, increase the pressure to escape through drugs.

Finally, I cite our willingness and capacity in the past to pioneer in efforts by government to deal with the drug problem. Let me just provide a brief history.

In 1965, New York State established the Narcotic Addiction Control Commission, now known as the Division of Substance and Abuse Services. In 1967, New York City began drug-free programs, a full 4 years before the establishment of the National Institute on Drug Abuse at the Federal level. NIDA was, at its inception, understandably concerned with the creation of new programs in areas where they did not exist before. The net result has been that the

Federal share of funding in other areas of the country is much greater than in New York City.

For example, $72 million was spent in New York City by all levels of government last year on drug treatment and prevention programs, of this $17 million, less than 25 percent, were NIDA or Federal dollars. In other parts of the country, the NIDA share approaches 75 percent. We ought to point out that even with the welfare maintenance, the Feds pay 50 percent, and it seems to me that they ought to bring up the share of the costs to at least 50 percent. Although the dollars are limited, we believe that they should be spent where the need is greatest.

Last year, approximately $12 million was spent in New York City on prevention programs which are primarily operated in the public schools. None of these programs received any Federal assistance. In addition, $35 million was spent here on methadone maintenance, of which less than $1 million was provided by NIDA, of that total $18 million came from medicaid, however, the Federal Government picked up only 42 percent of that cost, while the city and State each paid 29 percent. The city also provides $4.3 million of direct tax levy support for drug treatment.

Due to the fiscal crisis, since 1975, the city's and State's contributions to the drug program have been shrinking, as has our assistance to other essential programs. We have had to cut our budget, as you know, so that we live within our means, which is what we have to do, must do, and should do. At the same time, inflation has eaten away more than one-third of their annual appropriation.

Finally, local economic factors such as the disproportionately high increase in heating costs in the Northeast have compounded the problem. For example, here at Daytop Village alone heating bills have gone up 150 percent in the last year.

While we certainly recognize Federal budgetary constraints, we are concerned that the NIDA appropriation has remained fixed at $161 million for the past 2 years, sharply reducing the purchasing power of that money. There has not been an allowance for the inflationary costs.

We need a sharp increase in drug abuse funding, at least enough to meet the cost of inflation. We also need a distribution formula from NIDA, which takes into account the relative needs of different areas of the country, population and the number of addicts. The correction of past inequities in distribution of these funds is also very much needed.

We have a very fine network of services in this city that provides for prevention and early intervention and treatment. However, the effects of inflation are gradually impairing the capacity of that network to provide the level of services. Meanwhile, the continued spread of drug abuse is seriously eroding the socioeconomic fabric of the city, worsening its already serious fiscal condition.

I am here today not only to give you a picture of the drug abuse situation in the city, but to ask this committee for its help, and also to take advantage of the fact that you have the leadership in this area, you have demonstrated it, and you are a friend of the cities, not just New York City, and so we look to you and to this committee for assistance.

While we recognize that the need for expansion of prevention programs throughout the country, additional treatment funds are of the highest priority to the city of New York. The need is great, and we urge your assistance in securing increased NIDA appropriations, as well as assuring the city's fair share of available funds.

Thank you, Mr. Chairman.

Mr. WAXMAN. I want to commend you on your statement. It is an excellent outline of the problem.

From what I understand you are saying, there are many things that we have to do, both in the area of drug abuse prevention as well as treatment.

Mayor KOCH. Yes, sir.

Mr. WAXMAN. It is tragic to think that there is a competition for funds when we ought to be doing both prevention and treatment.

Mayor KOCH. Yes.

Mr. WAXMAN. Competition where one group is working on one aspect of the problem and feels that they are in competition with another group for very limited resources.

Mayor KOCH. Yes.

Mr. WAXMAN. The Federal Government invests money through the National Institute on Drug Abuse to assist drug abuse programs in cities like New York. You believe the Federal Government should contribute with more money to these programs to keep them going, and to do all the new things that certainly have to be done.

Mayor KOCH. I would suggest two areas. One, increased funding and also to make sure that the formula is equitable, and that the moneys be allocated on the basis of where the addicts are. The addicts tend to come to the larger cities, to come to New York City, or to come to Los Angeles or other major cities, and the formula should provide for that—putting the money where the need is.

At the moment the formula, if there is a formula—I think that probably the distribution is not based on a formula, but it is based on prior precedent—should be looked at.

I think that there is another area where the Federal Government can be of assistance. I have been interested in the various modalities as they apply to drug treatment programs, drug free, methadone, and the various, different competitive systems within the overall system.

I have never seen an area that is more competitive or that is more aggressive vis-a-vis one another. It is incredible, without naming the names, because that would not be helpful, but every single different agency—they all have terrific names, as you know—in the private sector, will compete and denounce the others, and talk about theirs as the best, and it may be.

The one thing that is missing in my judgment, and the one thing that the Feds could be very helpful on, is actually analyzing the net effects and go into the programs. We have not been able to do it here in the State of New York in an adequate way. The city does not have the administrative controls, and the State does, but it has not gone into the programs, to determine what the results are. This is necessary, because you never get a straight answer from the people who are involved.

They will tell you that the programs are terrific. The people who come out of the program, they will give you statistics as to how many remain drug free over a period of years, or remain on methadone and don't abuse other substances. But you never know what group you are really talking about, because they are only talking about the graduates. The graduates of the program, those who come through after an 18-month period, the number is very small compared to those who started. Therefore, you are talking about a very small group in terms of success rate. We really don't know.

So I am urging that whatever else you do, you actually go into the programs to see what, in fact, was the success rate.

I support the programs, because we have no substitute for them.

Mr. WAXMAN. What you say to me gives me some sense of frustration, because at one time the cities ran the programs. Through the statewide services contract, the National Institute on Drug Abuse has delegated program management to the State. I believe New York City gets over 50 percent of NIDA funds provided New York State. But in allocating drug abuse funds to a State, we expected them to monitor the quality of the programs. [See p. 132.]

What you are telling us is that this is not happening. They are merely sending the money out, and hoping that it is doing some good. We know the funds are doing some good, but are they being used in a manner which benefits the largest number of individuals in need?

Mayor KOCH. I am saying that we are not in a position to monitor, because monitoring costs money. There is no question about it. If we were to simply monitor the methadone programs that we have in the city, I was told coming up here by Dr. Bahary of our city, that it would cost one-half million dollars. We don't have one-half million dollars to spend on the monitoring.

Now, if you provide monitoring moneys to us, as well as the moneys that would be required to fund the agencies, fine.

Mr. WAXMAN. What role do you see for the city?

Mayor KOCH. I must say that if we had the moneys for the monitoring provided to us by the Feds, and given the power to do the monitoring to the fullest extent, I am delighted to do that.

I am supportive of the programs, I am supportive of them, I want you to know that. Until you come up with something better, I am for them. This one happens to be particularly good, and I know that of my own knowledge, and there are others that are equally good, there is no question about that. Then there are others that are not so good, I am sure. Until you get better ones, or better ways, I am for them.

I have always believed that there has been a dearth of monitoring, seeing whether or not they work. The boards of directors of these agencies are very powerful, in the best sense of the word, because every single one of these groups brings on the board, on their letterhead, the best names in the city, because it is helpful to them.

When you start asking questions, you find that you get calls from members of the board of directors saying, "You know, this is a very good group. You really don't have to worry about that," and they mean it.

What I am simply saying is, there should be formal monitoring to see whether the results are all that they say they are.

Mr. WAXMAN. Is it fair to say that we should either give additional moneys to the cities to monitor the programs, as well as continue to fund programs through the States, or the Federal Government should bypass the State and to distribute the money and monitoring authority directly?

Mr. KOCH. I have no problem with that. It is not like I am looking for home rule on drug programs, you understand. There are a lot of other problems that I am involved in. I have no problem in accepting the responsibility, if you provide the money to make it possible for us to monitor. But I would be even more desirous of the Feds monitoring.

Mr. WAXMAN. Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

Mayor Koch has probably put his finger right on what the problem is, as far as treatment is concerned.

We, who sit in the Congress, had come out with the funding for drug programs, and we had a famous colleague from Iowa, H. R. Gross, who would also offer amendments to cut New York's money on virtually every program, and drugs particularly. He would say, "If those New Yorkers want to use drugs, let them pay for the drug treatment programs."

Of course, we had statistically studied who was being treated in New York in the drug programs, and I pointed out to Mr. Gross that his constituents in Iowa had come to New York to use drugs. This is a drug center, a drug capital, and it draws from a substantial portion of the country. San Francisco draws some, and New Orleans draws some. Miami, of course, is going to give us some fast competition here as far as drug distribution is concerned.

I went from program to program nationally, through Lexington, Fort Worth, the military programs; I went up to see Dr. Bob Baird in Harlem, spending time there until 2, 3, or 4 o'clock in the morning while he treated people; I was at Daytop, at its very inception on Staten Island, when the communities were up in arms about it.

We realize that Daytop is not a panacea for drug treatment, but it will be very effective in a certain area for treating certain types of people.

Dr. Baird said, "I can only treat 25 people as an M.D., full time, working on people"—that was the ratio to him—"I will get over 50 percent cure."

Everybody wants to oversimplify this question of drug addiction. They say, "We have 100 percentile, and we are only going to cure 5, 10, or maybe 11 percent." That is not true. You see that 100 percentile is a very complex group of people, but our Federal program is oversimplified. We needed a Federal program, and the easiest thing was to do a methadone maintenance program on a national level, and take all the money away from the cities, where the need was, and where the effective programs were developed, because it is easier and it is cleaner to give the money to the State.

The States are usually so far removed from the problem that they don't know how to wrestle with the problem. They just don't understand the problem. It is easy to criticize the city, and they did

criticize this city. I don't know of any drug program that will not be criticized because of its very nature.

If we take this simplistic view on a national level and treat the drug program the same way handicapped education is treated, which is to cut the handicapped, and cut the drug people when money gets tight, because they are not very nice people. We say, let's take care of the mainstream problems in this society. We will do education, but not the special or the problem areas.

This drug problem is just as bad today, and it may be worse than it was 10 years ago. It is not jazzy anymore because after 30 or 60 days, when the media has had their play with it, and the public does not want to listen to it any more, then we just put it aside, and the overdoses will be picked up, and they will be categorized, perhaps not as a drug overdose, but some other type of fatality. Even the statistical count today is getting kind of fuzzy as we look at it.

But you have put your finger right on it, Ed. The city is the place that should run the drug program, because it has the people that are reacting to the problem. We have reacted in this city for decades, and that is why we were so far ahead of the Federal Government, so far ahead of the State governments.

I don't want to be political about it, but it started back in the Nixon era, when they wanted to be fiscally tight and started to cut back in areas that were easy to cut back. The drug area was easy to cut back because they did not have a big constituency to support them in getting funds. It really was the experts and the workers in the field that really wanted to do it.

I think that if we do a further analysis, your advice today of putting the city back in the game, will be more than adequately supported.

Mayor KOCH. But to provide the funds for the management aspect, not just for the maintenance of addicts or the programs. We have to have moneys to examine those programs, otherwise we don't want it. We cannot provide the tax levy funds for that.

Mr. MURPHY. Precisely. This is not a city problem. This is more than a national problem. It is an international problem. When Pope John Paul called all the Catholic drug treatment people into Rome several months ago, it was an indicator that it is a worldwide problem. The distribution is worldwide, and it is as sophisticated as can be.

We figure that $8 billion in drugs is going to be passed around, and that may be a modest estimate, with tremendous profits being made. You know that it is fully national. Why should New York have to set something up to fight what is a national and international problem? The Federal Government must come in and support the effort, not just in New York City, but in Miami, in San Francisco, and in other cities as well. But the main problem is here, right here in this city.

Mr. WAXMAN. Thank you very much.

Mayor KOCH. I have one last question, which has come to mind when we realize that there is competition and always insufficient funds for everything that we want to do.

If we gave more money to the cities for monitoring, how do we know that this money would not be competed for by programs that say, "We need it so desperately for treatment."

Mayor KOCH. I understand that. Therefore, when you set it up, you have to put a restriction, if you take this route.

Mr. WAXMAN. How?

Mayor KOCH. You must say, "This money must be used for monitoring, and not for treatment," otherwise there is no question that there will be the press to use it all for treatment. Obviously, you have to be for treatment, but you have got to be sure. If you don't monitor, who knows, you may be wasting a lot of money. Monitoring is key, and you have to have a set aside for it.

Mr. WAXMAN. Thank you very much. We appreciate having you with us.

Mayor KOCH. Thank you.

Mr. WAXMAN. Our next witnesses are a group of people, each of whom are undergoing treatment in New York City drug programs. Each has offered to share with us their personal experiences this morning. For privacy reasons, we will only use their first name.

I want to welcome each of you here today. We are grateful for your presence. By learning about your personal experiences, we hope to gain a better understanding of one of this Nation's most tragic health problems.

We welcome Jose, Tammy and Terry.

STATEMENTS OF JOSE, TAMMY, AND TERRY

JOSE. I would like to say good morning to everyone here.

My name is Jose. I am undergoing treatment at this time at the Daytop Village that is up in Millbrook. I am 17. I lived with my mother and my sister up in Brooklyn before this. My father, I don't know him.

I want to tell you that growing up in school, just being in Brooklyn, all the people there, it was like very hard for me to go through every day, because my mother and me we did not get along. There was no understanding between me and her. It was hard, feeling that there was nobody there to support me, giving me any kind of strength. My mother had to be a father to me, also.

From there, we were living in Williamsburg before I left my house. I was 13 when I first left. I moved to my grandmother's house and my aunt's house. I started smoking reefers at that point, I was 13, and I was like running around from place to place.

When I left my aunt's house, that was the last place that I lived in. I went to this home, and I met a lot of people there who were just like me. They were just getting high, drinking, smoking, and using pills and whatnot. I stayed there for about 3 months. There were few people there I liked, and it was like all over again I just had to get up and go somewhere else. I had no real place that I could call my home, that I could say, I live there.

I went to St. John's home. That is when I started stealing. There were a lot of kids there, a lot of boys. It was an all boys home. That is when I first got arrested for stealing cars out there. Again, it was like being lost, not having a father, and my family. Like not knowing, where do I go on weekends? Do I have a mother or do I not? Not ever being wanted, that is the way I felt.

From there, I came to Daytop. I went to an Outreach. I was living back home with my grandmother. I could not go to my mother's house. It was from 9 to 5. I used to go in the morning at 9 o'clock, and I met a lot of people there, like Joe Fishman and a few other residents there. I felt a part of it, just the way they treated me, by talking with me. The kind of concern that I wanted, they gave it to me.

Then, again, at 5 o'clock, going back out, and just going around in the streets, seeing everybody getting high and smoking, and drinking, it was like, where do I stand?

From there, I went to up to Swan Lake. I was at Swan Lake before being at Millbrook. I was there for 4 months, and everything was going all right. I felt a lot of confusion because I cared about people, and I like people there. I just turned around and I left.

From there, I was on the street for a while. Then I found out that it was like I had to go back because I had no place to go. I went back there, and they sent me back to the Outreach. It was like feeling alone, and nobody really cared. I left the Outreach after that, and I stayed on the streets for about 8 months.

I kept on smoking and drinking. I started using pills. Finally, a few months back, I started shooting coke and dope. I was living in buildings. I was sleeping in hallways. I used to sleep on the train. At nighttime, about 12 o'clock at night, I had no place to go, and I just used to take the ferry over to Staten Island, and sleep on the boat. I just felt like a bum, really, like I really did not belong to anyone. I felt like dying lots of times, like giving everything up.

I just my decision to go back upstate. I am in Millbrook right now, and I know that a lot of people care about me there. A lot of people are beginning to love me, and I like it a lot. I feel a lot of concern. I got loved there, and I felt that I was wanted.

This is all I have to say.

Mr. WAXMAN. Tammy?

STATEMENT OF TAMMY

TAMMY. Good morning. You are going to have to excuse me because I am a little bit nervous.

Mr. WAXMAN. Would you rather that I asked you some questions?

TAMMY. I don't know.

Mr. WAXMAN. Maybe we could just talk. We just want to know what your situation was so that we can learn. I am sure that you know what you have gone through is not unique. There are so many other young people who have gone through the same situation.

You have pulled yourself together and realized what was lacking in your life. You have participated in programs that were able to help you. We want to know what really helped you in terms of the program.

Tell us a little bit about the things you think we ought to know.

TAMMY. When I came to the program, the most important thing to me was the people. Without the people, I would never have made it.

For me, coming to Daytop——

Mr. WAXMAN. The people were supportive of you.

TAMMY. Yes.

Mr. WAXMAN. Did you start off with marihuana?

TAMMY. Yes.

Mr. WAXMAN. You started with marihuana, and then went on to other drugs?

TAMMY. Yes, because after a while marihuana just got to be nothing. At first, it was exciting, and then you just don't get as high.

Mr. WAXMAN. Your friends would say to you: "Why not try something else?"

TAMMY. Yes.

Mr. WAXMAN. What happened at home?

TAMMY. I started running away from home. I stopped going to school.

Mr. WAXMAN. Why were you running away from home? Were your parents reacting against drug use?

TAMMY. They did not know what to do, so they would hit me. They started sending me to psychiatrists and social workers, and nothing worked. So, I started running away from home, and I stopped going to school. There was no communication between us. We were not getting along.

Mr. WAXMAN. Did you ever get arrested?

TAMMY. No.

Mr. WAXMAN. Then you came to Daytop.

TAMMY. Yes.

Mr. WAXMAN. You said that the people were supportive. What kinds of things did they do? What did they say to you? Did you live at Daytop for a while?

TAMMY. First, I was in the Outreach from 9 to 5. When I first went there, my intentions were to get it over. I would please my mother, and go there from 9 to 5. It did not seem to work out that way, so I split. I ran away from home.

I started going to doctors, and saying, "I am a stewardess, and I need downs." Then I came back home 2 months later. My mother got petition out on me, and I went upstate. I went upstate, Daytop at Millbrook, but my attitude was still the same. I was a little brat, and I was a big baby, and I wanted what I wanted.

Then I got to love people, and sharing my problems, and telling me who I really was. I just wanted somebody to love me for me, and not for my money, or my clothes, or my body, and I felt that and that is what kept me there. But there were times when I did want to live.

Mr. WAXMAN. People that you worked with in the program started making you appreciate yourself?

TAMMY. Yes.

Mr. WAXMAN. That you are an important and special person.

TAMMY. Yes.

Mr. WAXMAN. Through the love of other people, and love of yourself?

TAMMY. Yes.

Mr. WAXMAN. Terry, do you want to tell us about yourself?

STATEMENT OF TERRY

Mr. WAXMAN. When did you first start using drugs?

TERRY. It is almost a different era. I started using in 1955, when I was 17 years old. The first drug I ever took was heroin. I did not try marihuana or pills, or anything. We were not as knowledgeable about drugs in those days as we are nowadays.

I became addicted to heroin, and from the time I started, I don't think that I ever really stopped from 1955 up until 1969. Through the course of my addiction, I was forced to steal to support my habit. I had 18 arrests, everything from loitering to narcotics, to burglary. I was in jail for approximately 6 years, in jail or in hospitals for drug rehabilitation.

I tried in I don't know how many different ways to stop. I was in Pilgrim State. I was in Central Islip. I was at the Federal hospital in Lexington, Ky. I was in Bernstein Institute. I tried Dr. Baird. I tried various treatment agencies around New York City. For me at that time just nothing was right.

I tried marriage. I met a nice girl. I fell in love. I told her that after the honeymoon I would stop using drugs. That did not work. Then she got pregnant, and I said, after the first child, I will stop using drugs, and then the second and the third. I just could not stop.

Mr. WAXMAN. What drugs were you using at that time?

TERRY. Just heroin, that is the only drug I have really ever used.

In 1968, I was finishing a parole violation. My family had left, they really could not be hurt any more by me. I could not blame them. My wife had divorced me. My outlook on life was just about nothing.

Someone told me about a methadone maintenance program. I did not believe that it would help. I did not know anything about it, but I felt that at that point I had nothing left to lose.

I got out of jail and I was on a waiting list for the program. I went to family court, because my wife was on welfare, and they had a nonsupport warrant for me. I sat down and I talked with her. I said that I was going to make one more try at life, and I was going to get on the program. I am not sure why, but she was willing to give it one more try.

I got on the program. I got a job working in a warehouse at $80 a week loading trucks, but it was honest work, and it was the first job that I had held in 15 years. I got support from the program, and I stopped using drugs. It was the first time in all those years that I was able to stop running, and to really sit down and take a look at myself, take a look at my wife, and try to do something productive.

Mr. WAXMAN. Have you stopped using drugs?

TERRY. I stopped using heroin. I was on methadone, and I am still on methadone. I have been on methadone for 11 years.

At that point, things just started getting better. I got the help that I needed from the program, and my confidence started to grow. My family came back and started to support me. I got better jobs, and I was successful. I was a salesman for a big company, and then I had my own business.

Then I went to work for Beth Israel in 1971. People that I spoke to in my clinic felt that my experience might be helpful to other people. To me, I think that it was a good choice.

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Since then, I now own my own home. I have a lovely wife and three children, about the age of the young people sitting here. I am fortunate, I think, to feel that, thank God, they are not using drugs.

Mr. WAXMAN. How do you feel as a parent? Do you have teenage children?

TERRY. Yes, sir; 17, 16, and 14, three daughters.

Mr. WAXMAN. Like all teenage kids, they are exposed to drugs everyday.

TERRY. Yes; they are. It is frightening.

Mr. WAXMAN. Do their friends use drugs?

TERRY. Yes; their friends smoke. There is a lot of peer pressure.

Mr. WAXMAN. How do you, as a parent, counteract this pressure?

TERRY. My children know my own experience, and maybe that has had some impact on them. I try to be open with them. I don't try to just scare them, and tell them stories because that does not work. Kids really are not afraid. I just try to give them the benefit of my knowledge and experience, and I try to keep communicating with them. I do, and my wife does.

I don't care what they do, as long as they can talk about it, you can keep it from getting really out of hand. Their friends smoke, they take drugs, and I think that they have tried it. Fortunately, at least, I don't believe that they are into it heavily.

Mr. WAXMAN. Tammy, your parents were afraid of drugs, and did not know what to do when they saw you were using them. They were probably horrified. Whatever earlier problems in communication you had—those became worse. Is that right?

TAMMY. They did not know what to do.

Mr. WAXMAN. Among the people you know in the Daytop program, is there an understanding by their parents of what helps kids?

What is helpful? What should the parents do? Should they be understanding? Should they accept it? Should they be hard and punitive? What do you think is the best way for parents to deal with drug abuse among their children? Most parents are not in the unique position that Terry is in, who knows the problem and who knows from his own experience what to say to his children so that he is credible, and the communication is clear.

TAMMY. I don't think that they should accept it. I think that they should try to find some information on what to do. Not to hit the children, but to be hard on them. It is nothing to accept.

Mr. WAXMAN. You came from a home where you had both a mother and father?

TAMMY. Yes.

Mr. WAXMAN. What was your relationship with your parents like before you got into the problems of a teenager on drugs?

TAMMY. I was jealous of my younger brother. He was like a mama's boy. He was closer to my family. I was always like the black sheep. My friends were the only thing I had.

Mr. WAXMAN. Not too long from now you will be a parent, and you are going to have to deal with children who maybe are going to be exposed to all the things that kids are today and maybe more. We see the problem increasing. What do you think you would do as

a parent, if you saw your children going to school and starting to use drugs?

TAMMY. I would probably send them to a program.

Mr. WAXMAN. How prevalent are drugs in school? Did you start while you were in school?

TAMMY. I started when I was 11. The teachers were getting high, too. They would get high with the kids after school. None of the films really helped either. It was just like, we don't have to do school work now. We will just go to the auditorium and fool around, not even watch the drug film. It did not mean anything.

Mr. WAXMAN. Were you at a particularly rough school?

TAMMY. No; my school was not that rough.

Mr. MURPHY. What area?

TAMMY. Queens.

Mr. WAXMAN. The teachers would get stoned with the kids right there at school, or after school?

TAMMY. After school. There were kids getting high in the bathrooms during school.

Mr. WAXMAN. Drug use was all very acceptable.

TAMMY. Yes.

Mr. WAXMAN. Nobody seemed to care, and nobody seemed to object to it, and if they showed a drug abuse movie, it was sort of a joke.

TAMMY. Yes.

Mr. WAXMAN. Congressman Murphy showed us this kit. You know that there are head shops all over the city which sell drug paraphernalia. What do you think that means to kids? Do you think it is a subtle signal to them that the drug culture is acceptable? Do you think that it would be a good thing not to have drug paraphernalia available?

TAMMY. I don't believe that they should have it around. To the kids at school, everything is cool. If the teacher gets high, that is cool. If a kid goes to school and carries books, and he is good in school, he is a faggot.

Mr. WAXMAN. What is your relationship with your parents now?

TAMMY. We are getting to know each other now.

Mr. WAXMAN. Do they take part in the program themselves?

TAMMY. Yes. They are at groups in Outreach.

Mr. WAXMAN. So not just the kids, but the parents would be brought in and involved.

TAMMY. Yes, so they will know what is happening.

Mr. WAXMAN. Do you think that is a good part of the program?

TAMMY. Yes.

Mr. WAXMAN. Jose, many kids enter these programs and do not succeed. In your program, did many kids drop out?

JOSE. I don't understand.

Mr. WAXMAN. A lot of young people enter a program to try to get off drugs. Then, they go back home, and they go back on drugs. Drug treatment is not always a great success story. Have you known a lot of people in your program that have had real difficulty, in freeing themselves from drug dependence.

JOSE. I take it back to myself. It all depends on you.

You see, I left, and what I found myself with is like really out on the street, with nobody. I made a decision either to bum around the

rest of my life, or to fix myself up. I say, let me come in and give it another try, and do something for myself.

Mr. WAXMAN. Are you on a methadone maintenance program?

JOSE. No; I am not using any drugs.

Mr. WAXMAN. You were able to break away from all drug use?

JOSE. Yes.

Mr. WAXMAN. What about you, Tammy?

TAMMY. Yes. I am in Daytop now.

Mr. WAXMAN. That means no drug use?

TAMMY. Right.

Mr. WAXMAN. Does the Daytop program have a methadone program, or is it solely a drug-free program?

TERRY. It is a drug-free program. Daytop is strictly a drug-free program.

Mr. WAXMAN. Terry, what are your thoughts about drug free as opposed to maintenance? The methadone maintenance program has worked for you.

TERRY. Yes; it worked for me, and the significant thing is that it was available when I needed it. For other people, other treatments have helped them. I don't think that there is only one treatment for drug addiction for drug use. We need all types of treatment.

I think that we need more treatment. The drug problem is not diminishing. It is growing, it is getting worse, and it is spreading to all parts of society. I just find it frightening, working in the clinic, and seeing the kinds of things that are going on. It is not going away, it is really not.

Mr. WAXMAN. You have been involved in drug abuse programs. You have been involved as a person who used drugs, and now you are a parent. What would you recommend to parents who have not gone through your experience? What should their attitude be? What should parents do to prevent drug use by their children?

TERRY. I think that parents are one component of it. I think that society is another component. I think drug regulation, prescription regulation is another component. I see prescription drugs as really getting crazy in narcotic abuse, as well as narcotic abuse.

The fact that you can buy that in any community in New York City, this drug paraphernalia, shows an acceptance of drugs by society. These kids, they are faced with that. They go out there, they see things like that. They go to school, and they see drugs being used.

Mr. WAXMAN. You said that the scare tactics don't work.

TERRY. No; not really. I think that we have to be knowledgeable. I think that we have to communicate. We have to have as much treatment available as possible.

I don't know that there is one easy solution. I think that it has to be a concerted effort by everyone. As Congressman Murphy said, even on the international scene, the drugs coming into the country, and the manufacture of drugs, it is a very huge problem.

Mr. WAXMAN. Thank you.

Congressman Murphy.

Mr. MURPHY. The interesting thing about these three people is the difference, the total difference between them.

As Terry points up, methadone was effective for him. The psychological training or group association for Tammy was successful

for Tammy. Jose had to hit rock bottom before he came out of it, or even made the attempt to come out of it. There are three separate and distinct situations here.

Who is supposed to take this whole group of addicted people and sort them out, to send Tammy to one area, Jose to another area, and Terry to another area, and these other people?

This is where government—when I say government, I am not saying, you, as Feds, are supposed to do it—has to train competent people right down at the level here that can say who is going to go where and understand this whole area, that whole scheme.

Who wants to get interested? Do people really want to get interested in helping addicts? We found that some of the best treatment people are other addicts, because the best con artists in the world are addicts. They could make you cry with their stories, and be out in the street to get a fix 20 minutes after they have left you. They know it, and it is hard to visualize and understand, unless you have the proper people at the working level.

What did we do 8 years ago, we got rid of the working level. The Federal program just got rid of the working level, and that is why addiction is where it is. We have not made any real inroads into correcting, or even developing the programs to the degree where at the working level we can sort out the Tammy's and the Jose's, and the Terrie's, and the George's and the Charlie's, and everybody else who should go to the different programs.

You have really pointed out visually the way it should be.

Mr. WAXMAN. Let me ask Jose and Tammy one more question.

Clearly we can distinguish, and a lot of people do, between marihuana and heroin. From what we know now heroin is a much more dangerous drug than marihuana.

Is it your experience, not only personally, but with other kids that come into the program, that they started out with marihuana, and then went on to other drugs?

Tammy, you mentioned that after awhile marihuana was not exciting and that you went on to something more.

TAMMY. That is right.

Mr. WAXMAN. Because people distinguish between marihuana and heroin, marihuana not being addicting in the physical sense that heroin is, and because we just don't know how damaging it may be to our health; many of the scare tactics that were used with marihuana were discredited when it turned out that nobody could really prove that all those horrible things were really true.

There are a lot of people who feel that we should not have criminal penalties for the possession and use of marihuana, and that we should not put people in jail for long periods of time, particularly young people. As a result of this attitude, there has been a loosening of the criminal penalties for marihuana.

Do you think, when we start looking at it from that perspective, that we are creating a climate of opinion where kids think that marihuana is all right, that drugs generally are all right, and that it does not make any difference which drugs they use or don't use?

JOSE. To me drug abuse, abusing just drugs it depends on what you use and you don't use. It does not make any difference to me whether I use heroin or I smoke marihuana, because I am doing it all for the same reason, to escape from my feelings, to not feel

myself and to go off into space and be by myself, and not being real with myself, and not facing everyday life as far as being responsible with the things that I am doing. It is all an escape. That is all it really is, no matter what you use.

Mr. WAXMAN. It really has nothing to do with the criminal penalties. It has to do with somebody trying to find an escape for themselves from their feelings.

JOSE. I don't understand.

Mr. WAXMAN. You know that it is against the law to smoke marihuana. You know that it is against the law to use heroin. It is against the law to go out and steal to pay for those drugs. But you did those things, and the fact that it was against the law did not make any difference.

JOSE. No.

Mr. WAXMAN. Tammy, from your middleclass background, do you think that this attitude about marihuana meant that people accepted, and kids accepted any kind of drug equally, or do they still make distinctions between marihuana and heroin?

TAMMY. The kids that I know, mostly they made everything equal. It did not make a difference.

Mr. WAXMAN. We have been joined by Congressman Mickey Leland, who is from Houston, Tex.

You have not had the benefit of hearing what our conversation is all about. These are three people who have been addicted to drugs and are currently involved in local drug treatment programs.

We have been discussing various aspects of their treatment experience, and it has been very interesting.

Mr. MURPHY. Tammy, did your parents ever take you to a psychiatrist, when they first realized that you were on drugs?

TAMMY. Yes.

Mr. MURPHY. What about before they realized that you were on drugs, that there was a problem with you in the home?

TAMMY. No.

Mr. MURPHY. After you got on drugs, then they took you to a psychiatrist?

TAMMY. Yes.

Mr. WAXMAN. That was a shock.

TAMMY. They did not know what to do.

Mr. MURPHY. How long did they have you at the psychiatrist?

TAMMY. This psychiatrist who evaluated me said that I was crazy.

Mr. WAXMAN. How do you know that?

TAMMY. My mother told me.

He sent me to St. Vincent's Hospital, but it was a locked ward, so my mother decided not to send me there.

She got in touch with the drug counselor at school, and they found out about Daytop.

Even the psychiatrist did not help me. You go there for a couple of hours, and tell them a whole bunch of baloney. You go there for an hour, and then out and get high anyway. I could not deal with it.

Mr. MURPHY. But your parents did get you there?

TAMMY. Yes.

Mr. MURPHY. Jose, did you get any type of psychological counseling, or any community mental health counseling of any type?

JOSE. I was supposed to go with my mother by order of the court. It was not because of drugs, but because of the way our relationship was. Like I would always leave my house, and the problems in my house. I only went there for a few days.

Mr. MURPHY. Did the court mandate that you go?

JOSE. They told my mother that she was supposed to go, and to bring my sister.

Mr. MURPHY. With what frequency were you supposed to go? How often were you supposed to go?

JOSE. I don't know. I really don't. I know that I was supposed to go with my parent, with my mother and my sister. I only went once or twice.

It was not like knowing about me. It was like, "What did you do yesterday," or things like that. It was like he did not know me. He had me written down on paper.

Mr. WAXMAN. You have a sister?

JOSE. Yes.

Mr. WAXMAN. Do you have a brother?

JOSE. I have a little brother now. I think that he is going to be 2 years old.

Mr. WAXMAN. How old is your sister?

JOSE. My sister is 15.

Mr. WAXMAN. Does she have a drug problem?

JOSE. No, fortunately.

Mr. WAXMAN. Tammy, you mentioned that you had a younger brother. Do you have any other brothers or sisters?

TAMMY. I have a younger brother, and then an older brother and an older sister, and they both get high.

Mr. WAXMAN. How old are they?

TAMMY. My older brother is 30, and my sister is 28. My brother lives in Texas and my sister lives in North Carolina. I used to get high with them. They would think that I was the crazy one, if I were to tell them to go to a drug program, or to go to get help. They would think that I was nuts. They would not go.

Mr. WAXMAN. They got high from what?

TAMMY. They used to take pills. My sister drinks a lot, and they both smoke pot. But they are both miserable.

Mr. WAXMAN. Are they aware of your successful experience with the drug program?

TAMMY. They know, but they don't think that they need help.

Mr. MURPHY. Terry, how old were you when you started heroin?

TERRY. Seventeen, and that was in 1955. Drugs were not as watched as they are now. Someone moved into the neighborhood and brought this white powder, and we started taking it.

Mr. MURPHY. How did you take it.

TERRY. First intramuscularly, and then I ran it into the vein. It did not take long. It was fairly continuous from the beginning.

Mr. MURPHY. How did you survive?

TERRY. I survived from the resources of friends and family. When I dried up the resources of friends and family, I started to steal. I sold it at one point just to support my own habit. I never made any money from it. Then I stole, and that is when I started going to

jail. Then there was the breakup of my family. I would not want to do it again.

Mr. MURPHY. The guy that sells this complains about not enough police to protect him from the junky who is breaking into his place. Did you know that?

TERRY. I am sure of it.

Mr. MURPHY. You are lucky to be alive.

TERRY. I am very fortunate, I realize that.

Mr. MURPHY. You don't find users of your age who started out like this. They either wake up in the gutter, or they don't wake up. You don't find any old junkies.

TERRY. Yes.

JOSE. Yes.

Mr. MURPHY. You were lucky to wake up and realize that you had to come out of it.

TERRY. Most of my friends are dead that I started out with.

Mr. MURPHY. Or cured.

TERRY. Or in jail for life.

Mr. MURPHY. That makes an interesting statistic in drug abuse treatment. We don't count the dead ones. We only count the cures and noncures.

Mr. WAXMAN. I appreciate your talking to us, and giving us a perspective that we might not otherwise have had when we look at how Federal drug abuse funds are utilized.

Thank you.

Our next witness is Ms. Wilma Feldman. Ms. Feldman is a certified psychotherapist and a graduate of Daytop Village.

Thank you for coming today. You have a pretty long statement. We will place your entire statement in the record of the hearing, and I would like to ask you to summarize it, so we will have more of a chance to talk. [See p. 26.]

STATEMENT OF WILMA FELDMAN, M.A., C.R.C., CERTIFIED PSYCHOTHERAPIST, CONSULTANT TO DAYTOP VILLAGE

Mrs. FELDMAN. I want to thank you for asking me here today. What I want to talk about is prescription medication abuse. I have a very deep concern about the problem because I was a prescription abuser for many, many years. I think that the problem has grown alarmingly.

I want to make a correction in the testimony, because I think that it is important. I stated that there were 45,000 prescriptions, and that is in error. In 1978, just as a beginning, there were 45 million prescriptions written for Valium alone, and I think that that in itself says something.

It is a pretty scary situation about me. I was married to a doctor back in 1951. We had been living up north, and we moved down South, and drugs were a way of life for us. The marriage was very bad, and if I would complain about anything in any way, the response I got from my husband was, here is a pill to feel better.

I have to say that I was no angel, and I became an abuser. There was no respect for drugs in my household, and I think that my type of problem happens a great deal with physicians, with their families, with anybody that is exposed to prescription medication.

Over the years, the intake would sort of depend on how bad the family situation was. Of course, it got worse and worse, and as the family situation got worse, my pill intake increased. But it was usually done quite legally though, if not my husband handing me something, another doctor, always in prescription form, and this is the thing that I want to stress.

Somewhere along the line, it dawned on me that other people were not living like that. Taking pills was not a solution, and it was not a way of life. My first full realization of the trouble I was in, was when I went to a doctor and spoke about it with him, and he said: "Well, just quit." I was taking Miltown at the time.

I just quit, and within 24 hours, I convulsed, I hallucinated, and I became quite psychotic. I had to be hospitalized, and I don't know how they brought me out of it, but they did, thank God.

The thing is, here I went in to get off of one batch of medication, and the doctor's final answer, and I cannot tell you how many times I heard the same response, was, "You are either on the wrong dosage, or you are on the wrong medication." So it seemed like many years of being switched from one type of medication to another, all very legal, always from the doctor who is supposed to know what to do and how to handle you, and did not.

After this first episode, there was a decision made that I was crazy, and we began a round of psychiatrists. This continued for many years. The thing is, it was a repetition of what had gone on before, always: "You are not on the right medication, or the medication is OK but the dosage is wrong." Of course, I added to the problem by going home and just helping myself, and that is what an abuser can do.

Again, it went on for many years. It is a painful thing for me to talk about. We were living down South at the time, and I have four children. The marriage in the meantime just kept getting worse and worse, and there was nobody over those years who tried to help me attack the problem. The whole concept was that a pill was going to be my solution, and the sad thing was that the pill was never my solution to any of that.

The problems kept persisting. They kept getting worse. In fact, the fact that I was taking pills just made the whole situation that much worse. Again, it went on for a long time. I was finally able to leave my husband through various circumstances, and I came back to New York.

I had some idea that leaving him would solve the problem. I would be able to stop drugs if I left him, but by then pills and prescriptions, and looking for help in survival, the pill was so much a way of my life that I could not. It was another bout of the convulsions, and hallucinations from Valium, when I was told to quit cold, and I was dumb enough to try that. Within 24 hours I needed hospitalization.

I think that it was partly the amount that I was taking, I was taking more than was prescribed at the time, but I think there is also the factor of my own individual body chemistry. No one told me along the line that you should not drink. Drinking was never my problem. But I take a look at these factors as very alarming things.

In 1971, thank God, my parents found Daytop, and with it I began learning the concept of what a drug-free life was all about, and I think that that is a concept that is very important to take a look at.

I lived in. The program helped me. It saved my life. I don't really recommend standard drug treatment for my type of problem. I think that there are other ways, and I think that this is something that has to be looked at. However, the program gave me life, and it gave me a clear mind.

Just to show you the difference in lifestyles. From this picture that I have been giving you of an addicted, drug abusing, immobile person, whose life revolved around finding the right pill as the solution, after I graduated Daytop, within not too long a period, I began working for Daytop, working with parents, where my identification, of course, really lay, as a consultant.

Some of my old dreams from before my marriage came alive, and I went back to school. I got a master's degree in rehabilitation. I want to learn more and more about people, so I entered analytical training. I now have a private practice as a therapist. My interest has definitely swung back to the fact that there are many, many people out there like me, in trouble who need help, and this is what I am trying to do now, to see if something can be done to help those people.

This shows you the change in lifestyle from being a drug abusing, very legal, nothing illegal about it, to being a person who now is a firm believer in being as drug-free as possible.

Shall I continue with other things that I would like to get across, or do you want to ask some questions?

Mr. WAXMAN. Please continue.

Mrs. FELDMAN. To go back to how widespread the problem is, let me repeat again this 45 million prescriptions that were written in 1978. I got some statistics from DAWN, the Drug Abuse Warning Network, through the National Institute of Drug Abuse, and where drug related problems are concerned, and I am not just talking about Valium, this includes the barbiturates, the sedatives, the non-narcotic pain killers, but I am just talking of the Valium statistics alone.

In 1978, there were over 50,000 emergency room mentions of the problem, and this is just from those hospitals that report to DAWN. The emergency room rank for Valium was No. 2. The medical examiner's rank was No. 3. I have heard a lot of questions about Darvon, whether Darvon is creating a problem or not, Darvon was No. 2 in the medical examiner's rank where drug related statistics are concerned. I think that this says an awful lot.

I could not find any such specific statistics for New York City. If you bring it down to the proportionate number of people here, I think right here in this city we have a whopper of a problem.

I was also on the Donohue Show back in the spring about this problem, and the number of responses I got was really overwhelming of people in New York and all over the country who recognize the fact that they have a problem. I want to point out that these people are not going to a doctor to get high. They are not what you would call the stereotype picture of the drug abuser. They are under a lot of stress, they are having a lot of problems, they are

going to the doctor, whose opinion they respect and who they trust, and this doctor is ending up getting them hooked.

You know, it is like they are getting a bum steer, it is the way I look at it.

If you are wondering what is wrong with the medical profession that they can be so liberal in writing out prescriptions—I hear doctors say, "It is not a problem. You are building a mountain out of a molehill." I know from my experience, and I know from these statistics that there is a very serious problem going on out there where prescription medication is concerned.

Mr. WAXMAN. Why do you think doctors are doing that?

Mrs. FELDMAN. To start with, I have a son who is just finishing medical school, and I spoke to him, and I have spoken to other doctors, and I found out that the amount of training given in medical school is ridiculous. My son tells me that he has a superb course in pharmacology because he has a weekly course for 6 months, and it is one of the longest given in any medical school. The usual, I found out, is about 2 months with 1 hour a week.

That strikes me as kind of peculiar. There are 45 million prescriptions written for Valium, and there is a minimum of study in the field of pharmacology. I think this shows that the doctors don't really have the training to start with.

Mr. MURPHY. Mrs. Feldman, the pharmaceutical companies spend 25 percent of their income on promotion with doctors for dispensing of that type of medication.

Mrs. FELDMAN. That is right, and I was going to bring that out, because I watched my husband being educated by the detailmen. Those detailmen are out to sell, the same as the pharmaceutical companies are out to sell. You know, it is sort of a matter of economics versus lives and moral responsibility. I know that you are out earning a buck, but what about the people whose lives you are putting in jeopardy? How do you issue drugs on the market, push them, and then the doctors prescribe them without really knowing what the effects are. I am a good example.

I don't know if any of you are familiar with Barbara Gordon's book, "I Am Dancing as Fast as I Can." There is another case.

Maybe if I share with you some of the cases of the people I have worked with, people that came to me in response to the Donohue Show, or from other referrals.

I had a 26-year-old woman whose parents were both physicians, again people of the medical community itself. When this woman was 11 years old, she was overweight, and her parents put her on amphetamines. She is now 26, and she is on a second marriage. I hope that she lives—the way she is going she will take any pill that is in mamma's or daddy's medicine chest.

She told me about an OD, and waking up and trying to withdraw, and the hallucinating and the convulsing, and mommy and daddy were right there handing her barbiturates so that she would feel better, and not taking her to a hospital where she belonged.

This woman is not ready for treatment. With all of this, she is still denying that she has a problem, but this woman could wake up or not wake up, as you mentioned before.

I have another young woman, 33-year-old, very attractive young woman, who began drinking when she was 17. She was under

psychiatric care prior to seeing me for 10 years. This psychiatrist, knowing that she was an alcoholic, prescribed every kind of tranquilizer in the book for her. When I saw her, she was just coming down off Valium and alcohol.

There is another one. What are the doctors doing? I don't fully understand their concepts. Where is their sense of moral responsibility? I think that this is what I am trying to get across.

Then there was an older lady, a lovely lady of 75 that my heart really went out to, who 15 years ago went to a doctor for insomnia. The doctor prescribed Tuinal plus Librium. Later it got switched as the styles changed, because I found out that that is part of the picture, both from the doctor and from the patient. By the way, the patient is part of the problem, too.

Anyway, she was on Tuinal and Valium. Her grandchildren had found out what pills she was using, and they were calling her "pill-head," because it seems Grandma was using the same things they were buying on the street.

She went to her doctor. Her doctor said again, "Just quit." She tried. She became very agitated. She could not handle the quitting. She really did not know what to do. The thing is, with that type of long-term usage, and this woman was not what you would call an abuser, she was pretty much following the doctor's prescription, this woman could have died. Where is the knowledge the doctors are supposed to have.

Her family was saying: "You are 75. You are too old to change." That is pretty sad. She could not afford any treatment. I referred her to a hospital for detoxification. She is one of the ladies that I intend contacting somewhere with the hopes of maybe providing services for her, because she cannot afford any of the more professional services, and then it can be very doubtful as to how many psychiatrist-physicians are really aware of what the problem is all about.

I want to speak about people themselves, because I think that it is part of the problem, the patients going to the doctors. We are brought up to look at our doctors as knowledgeable authority figures, who would help us, and not hurt us. There is like a deep-rooted belief in what doctors are going to do. There is the feeling that the doctor is an authority figure. He is not someone you question because, after all, he has had many years of medical training, and who are you to question, plus the fact that you are very vulnerable when you are sick.

Many people really do not know the dangers of the drugs, and they accept a prescription blindly. So a great part of what has to be done is teaching people, and teaching the women in particular who are going after these drugs, that they have the right to question the doctor. They have the right to consider the alternatives.

We have to establish the concept that doctors offer alternatives to people. In other words, you have to have a flow of conversation about the dangers of the drugs, what can happen if you go on them, and alternatives, because there is never a solution to a problem in a pill.

You are going to the doctor because you are under anxiety, you are under stress, you have a reason. You are offered a pill, but what good does that pill do. You may get momentary easing of the

anxiety, but the effect of the drug wears off very quickly, so it is a cinch to become an abuser, because you are looking for more of a peaceful feeling from the drug, but the problems that sent you to the doctor in the first place are still there anyway. So what good does it do?

I can look at one of the questions I was asked, "What is prescription drug abuse?" I think that sometimes that first prescription that is written, the first pill that is swallowed by the patient can constitute abuse if alternatives are not looked into. It does not seem that they are being looked into, when there are that many prescriptions being written in 1 year.

[Testimony resumes on p. 34.]

[Mrs. Feldman's prepared statement follows:]

STATEMENT OF WILMA FELDMAN, M.A., C.R.C., CERTIFIED PSYCHOTHERAPIST, CONSULTANT TO DAYTOP VILLAGE

My testimony at this hearing stems from a very deep concern about the use, abuse and addiction to certain prescribed medication. I had this problem myself for many years of my life - a total of 17 years - and therefore am thoroughly aware of the problems and pitfalls of this type of abuse and am troubled that proper treatment is almost non-existent.

From approximately 1954-71, when I entered Daytop, I was involved with various forms of stimulants, barbiturates and tranquilizers, and pain killers. I was then married to a physician who introduced me to my first questionable medication by giving me a bottle of SKR's for menstrual cramps. This is a combination of amphetamine, barbiturates and aspirin. Plain aspirin, in fact, would have been quite sufficient. My marriage was very bad, I lived in Florida away from friends and family and four children were born in rapid order. I was convinced I was ill. I know now this was psychosomatic reactions to the stress I was under and I compounded my own emotional pain by going from recommended dosages to abuse. This is not a unique situation! The easing from the drug is very temporary and the problem remains. Over the years, I suffered reactions to such drugs as Miltown, Librium, Valium, Thorazine, Stelazine, Dexedrine, Darvon, Elianil and Nembutal. The realization of a problem grew slowly as I encountered people whose survival and lives did not revolve around their pill intake. The full impact came when I complained to a doctor and was told - OK - I won't prescribe - just don't take anymore. I quit cold - convulsed, hallucinated, became pseudo-psychotic and needed hospitalization to "bring me out of it". After this I was really serious in looking for help and I knew from the above experience that quitting was not the immediate solution. This

began years of rounds of psychiatrists and detoxification wards, all of which I would enter with one form of the above medication and leave with another. The treatment revolved around finding the "right medicine" which was also a reinforcement of my belief in illness and that I was crazy. By then I knew how and where to get what I wanted, but always through a physician or pharmacist. Needless to say, all areas of my life and those around me suffered. I was constantly depressed, hostile, anxious and immobilized and there was no one who knew how to treat this problem properly.

In 1971 I entered Daytop with a strong will to live and solid advice - finally, from a drug-free program - that my life would never get in order unless I was drug free and able to understand with a clear mind. As proof of point, I graduated Daytop in 1972, went back to N.Y.U. for a Masters Degree in 1973-75, while raising 2 of the children and holding a full time job. I began work as a Consultant for Daytop in 1973 also. In 1975 I entered my present studies as a psychotherapist and am in the process of completing this period of schooling. I have also left my work with New York City as a social worker and am now with Daytop doing a proposal addressed to this very problem. There are still no programs to treat this problem! I am, therefore, also speaking to you from the viewpoint of a professional whose studies have revolved around this problem and as an ordinary person who hears talks wherever I go and still encounters this problem personally on a level of known statistics to prove the extent of this problem. From NIDA (National Institute on Drug Abuse) and DAWN (Drug Abuse Warning Network) <u>Valium, as a tranquilizer, is the most widely prescribed drug in the United States</u>.

Question: Why should a mind-altering substance rather than a life-saving substance be in the lead? The last time I was detoxed prior to becoming drug free, the length of time was 30 days of slow withdrawal to this: valium, darvon and nembutal to avoid convulsions and psychoses! This is how dangerous these drugs are.

The drug categories reported most frequently by DAWN III emergency rooms were in descending order: 1: tranquilizers; 2: barbiturates and non-barbiturate sedatives, 3: the narcotic analgesies and finally 4: alcohol-in-combination with other drugs. See report 1978, of the Program for Women's Concerns also from DAWN, 1978, Estimated Emergency Room Mentions of valium: 50,200. Emergency Room Rank #2, Medical Examiners Rank #3, Estimated RX's 45 million and this is for valium alone!

A 1978 survey of NY State showed 1977 users of valium estimated at 1,126,000 the total estimate of users of tranquilizers for 1978 amounted to 2,475,000 persons and in 1977 there were 14,400,000 prescriptions written for tranquilizers in NY State alone. This should show the extent of the problem and the lack of programs for education, prevention and treatment.

Interestingly enough, I have so far been unable to locate any statistics for NYC alone. I am told by very knowledgeable people that this type of breakdown for NYC does not even exist and the Medical Examiners Office cannot provide any such statistics. This is an interesting fact for the largest City in the U.S.; the center of the drug culture and probably the largest concentration of physicians to quote the NY State Report. Assuming that NYC physicians prescribe in a fashion similar to the Country and State, these psychotropic drugs are undoubtedly very available.

Again, why prescribe psychotropic drugs? Other interesting points pertinent to this hearing and showing the changing picture of drug addiction from the State are:

- of students reporting non-medical use of prescription drugs, about half obtained them at home - medicine chest, parents, family (how teenage addiction begins)

- there may be extensive use of pep pills and tranquilizers on the job (I know, I was working and stoned for some years)

- the use of the drugs we are discussing is much more common among women than men.

- in New York State about 3% of persons 65 and older have acquired prescriptions for tranquilizers, sedatives and stimulants.

As further proof of point of the existence of a severe problem:

When I go to a physician I will immediately notify them of my past problem. Yet I have only been to one physician in the past seven years who did not, with this knowledge - offer and insist that I take valium - darvon - librium or what not-after all, I am told, I should be able to control myself. If I ask why are they prescribing this, the reactions range from being affronted at being questioned to outright hostility: "I know what you need". "These pills are really harmless" or "well if you don't want my prescription - why come in the first place". I have never over the years had one physician tell me that possibly some counselling or therapy would help with the stress problems as a preferable alternative to taking a pill.

As a practitioner, I have met the following people and these are

very typical cases.

Mrs. C.G., age 26: parents both physicians, was placed on amphetamines at age 11 because she was overweight. Has constant access to anything available in her mother's drug supplies. Has suffered several OD's, convulses and hallucinates when she tries to stop taking anything available, mainly barbiturates, tranquilizers and sedatives and some percodan. She is not yet ready for help. In that environment she cannot envision life without a pill!

She is also likely not to wake up from an OD (overdose) one of these days and is another case in point of the prevalence of the problem with physicians, nurses and physicians families who have the easiest access to tranquilizers and stimulants to "keep going". Question: Who said you need that pill to keep going?

Mrs. T - age 75: on prescribed Tuinal plus first Librium, now Valium, for 15 years. Prescribed for insomnia. Her grandchildren call her a "pill-head" because she takes the same drugs that they buy on the streets. She does not want to feel dependent on these drugs, tried to stop and became extremely upset and went back on them. They no longer do any good and she occasionally will take more than prescribed. (Typical pattern of going from use to abuse!) Her doctor tells her just quit, they are harmless and her family tells her why bother - you are too old to change! She was referred for detox to a L.I. Hospital, could not afford private fees and there was <u>no</u> specific program that could help this lady at this point.

Miss P.K. Age 33: alcohol at 17 years. Began seeing a psychiatrist who prescribed many different types of tranquilizers, mainly

valium and librium while fully aware of her drinking problem. This is a set-up for possible death! This is evidence of the lack of knowledge for treatment. She has been seen as a private patient for about 5 months in conjunction with AA and has not had a drink or a psychotropic drug during this period and is really struggling to get her life in order. She can see a different personality in herself now that she is drug free.

Mrs. S.F., age 54: went to a physician for stomach ailments and a history of severe stress because of family problems. X-rays ruled out a physical basis and valium was prescribed for her "nerves". She felt better for a short while, but soon the valium lost its effect; and she would take 2 pills as opposed to 1. She is now heavily addicted. She can use as many as 6-10 mgs. daily. No problem obtaining the drugs. Has her route of physicians and some drug stores to get them at. The family problems - well, her husband walked out on her and her children ignore her. This is not atypical. Why did the doctor recommend valium rather than counselling in the beginning? Granted, he did not know Mrs. F. would become an abuser, but that is almost inherent in the nature of this drug! Why not even valium temporarily with counselling? Again, why the prescription as opposed to the problem solving, that is one of the questions we must address ourselves to.

On a socio-economic level, NYC Medicaid is beginning a crack-down on abusers through their computers for poverty level people, through your middle-class section, right up to Betty Ford. I would recommend reading Barbara Gordon's book for one case history.

***My emphasis here is that the problem begins when the first psychotropic drug is prescribed without questions as to why and without

considering alternatives. There is something very wrong with a society that reaches for a pill to "feel good" the first step is admitting to a problem!

Why do we have this problem and what can we do about it? New York State Office of Drug Abuse calls this a 4 "P" problem.

1. Pharmaceutical companies issuing drugs before the dangers are fully known. Irresponsible ads in journals and detail men or drug salesmen are becoming the learning source for physicians. I watched my ex-husband learn about drugs through detail men whose sole purpose is to make a sale - the manipulation of students and office personnel with gifts is extensive. This is big business where economics takes precedence over mental health and one of the most down-graded areas of living because of stigma and outmoded belief structures.

2. Pharmacists: It is not too difficult to find one that will supply drugs without prescriptions and how often will a drug-store report an abuser. Again - economics over lives.

3. Physicians: What exactly is medical school training in pharmacology? A few weeks! Six months of once weekly courses. Contrast this with valium as the leading prescribed drug. How dare a G.P. or an internist prescribe something like thorazine. At least a psychiatrist has had more extensive study in the area of psychotropic medication. A woman is more apt to admit to nervousness than a man - it is more socially acceptable. Her doctor is the all knowing benevolent father who will make her better. What needs serious investigation is why the good doctor prescribes a tranquilizer rather than suggesting an alternative.

The solution to stress or problems can never lie in the pill itself!

4. Patients: People must be educated to the dangers of this problem. They must be taught that they should and have a right to question medication and ask for alternatives. They, too, must learn that solutions do not come in pill form. This is difficult when one sees the TV world of take a pill and feel good! And if one becomes aware of the problem; treatment must be available!

In summary:

The problem of prescription abuse begins at the point of blind, trusting use. More controls are needed at levels prior to the drug reaching the patient. Abuse may therefore range from usage when alternatives are not considered to anyone exceeding the recommended dosages. Why do pharmaceutical companies issue and recommend drugs without being aware of and advertising the dangers? The drugs we are discussing are highly addictive so we must address ourselves to the fact that the leading prescribed drug, valium, is an addictive, mind-altering substance and ask ourselves what are we doing to this country!

Programs must be instituted on levels of controls for the pharmaceutical companies, pharmacists, and physicians. Education for physicians is essential, as is programs for education and awareness for the people. Treatment programs designed specifically for this problem must be instituted with sensitivity and understanding of the feelings of the shame involved on the part of the abuser who is probably a functioning worker, housewife or what have you. Remember, these people were simply looking for help for physical pain or emotional stress and got steered in the wrong direction. First, these people must be educated to the fact that they have a problem and this becomes the first step in recovery!

We, as a country, must begin also to question our drug-oriented society. We cannot truly live or survive when pills become a cure-all and a substitute for life.

Mr. WAXMAN. You mentioned that you have four children.

Mrs. FELDMAN. Yes.

Mr. WAXMAN. The oldest one is a doctor?

Mrs. FELDMAN. He is finishing medical school right now, yes.

Mr. WAXMAN. What was it like for you as a parent with children who were teenagers? Did you have a particular sensitivity that exposure to drugs through peer pressure might be a problem for them?

Mrs. FELDMAN. Certainly, I had a special sensitivity to it. My two oldest boys are doing remarkably well. One is in medical school, and the other one is a nuclear engineer from MIT. How they came out of it, I often wonder, with the background I gave them. They had a drug addicted mother floating around, and it was bad for them. I think, in certain respects, they are miracles. They have told me that they tried pot out of curiosity, but they never got involved in the drug scene.

The two younger ones are another story.

Mr. MURPHY. Did they know that you were addicted?

Mrs. FELDMAN. Yes, they did.

Mr. MURPHY. When did they find out?

Mrs. FELDMAN. I cannot pin down exactly when, but it probably was with the first convulsion, and probably then when it was so obvious. They may have suspected before that, I really cannot tell you. I gave them a hell of a time, I can tell you that.

Mr. WAXMAN. As a result of your own experience, you are currently involved in helping people.

Mrs. FELDMAN. Yes.

Mr. WAXMAN. Are the people you are primarily helping women who have gone through an experience similar to yours with what we consider legitimate, certainly legal drugs like Valium which are prescribed by physicians.

Mrs. FELDMAN. Yes.

Mr. WAXMAN. Do you also work with those who have problems of drug abuse from marihuana and heroin, the illegal substances?

Mrs. FELDMAN. I have worked with all sorts of people. My work was at Daytop until this point. My work has been with families, with the parents. This has been my prime work.

Through my private practice, which is another story, as I have said, I am beginning to see more and more people. What we need is ways of educating the public.

What the government does with the controls of pharmaceutical companies and pharmacists, there is a problem there, too, in the sense of your friendly pharmacist who will always be glad to help you out, since he knows your face, and he is someone who could control the prescription flow, too. There are other factors.

I have had pharmacists tell me that they know which detailmen have been in the area by what prescriptions are written out. That, I think, is up to Government controls.

Mr. WAXMAN. Is it easy to get a pharmacist to help you out?

Mrs. FELDMAN. Sure, you can always find one. It is not that difficult. You make friends.

Mr. WAXMAN. What do you advise parents to do when they discover their children are using or abusing drugs?

Mrs. FELDMAN. What I did with my two younger ones. I referred them to a drug program, whether they went along with it or not was another story. I had occasion to throw one of my sons out of the house. Thank God, he is doing very well now. My daughter is a Daytop graduate, as a matter of fact.

Mr. MURPHY. How did you get that tough to throw him out; how?

Mrs. FELDMAN. He was refusing help. He was laying around the house not doing a darn thing. He was lying to his teachers, and he started stealing from me. I am a Daytop graduate. I think that it affected me much more strongly than it might have other parents. I told him to get out, but I knew that he had enough money to go to his father, and that is where he was told to go.

I have had my own personal problems with my kids. But he is doing fine now, thank God. He was helped very much by Daytop, too. He is not a graduate.

Mr. MURPHY. He would not be fine, if you had not gotten tough.

Mrs. FELDMAN. You are right. It needed a get tough policy. That is what it takes, and that is what we teach our parents to take. It has to be done, and you have to take a get tough policy. It is either/or. You go into a program, or good bye. It is very difficult. It was hard for me.

Mr. WAXMAN. Mr. Leland?

Mr. LELAND. Mrs. Feldman, I am certainly glad that you pointed out that the doctors and the pharmacists are, indeed, the problem.

Let me just say that when Congressman Murphy mentioned the fact that the pharmaceutical companies spend about 25 percent of their profits on advertising and trying to induce doctors to write their particular prescriptions, it is a very interesting figure. To be more precise, it is over $1 billion that they spend in these types of activities.

It is an incredible amount of money that they spend, not only on doctors, but on medical students, and hospitals, providing them with all kinds of information.

Mrs. FELDMAN. Have you looked at the ads in the medical journal. They are unbelievable. I was told that they have changed, but they have not. I recently saw one in the New England Journal of Medicine, which is a topnotch medical journal, where the woman, "is she cranky, is she irritable. If she is, give her Valium, and she is going to be a nice lady."

My son was telling that on his first day of medical school, all of the new students were presented with stethoscopes as a gift from one of the drug companies. In his rotations, there are coffee and doughnut breaks furnished by your friendly pharmaceutical company. So I can well imagine what is going on with that.

Mr. LELAND. They pay moneys also for trips to Hawaii, to the Caribbean, and other exotic places. There are all kinds of inducements.

I know the problems that we are discussing here from an intimate point of view. I studied pharmacy, and I am a pharmacist in addition to being a Congressman. They did not do that for pharmacists.

This is the irony that you are talking about. The pharmacists go through a lot more training in pharmacology and toxicology. They learn about all the ramifications of what happens if you use two or

three drugs at one time. They understand the synergistic effects on a person who is depressed, but a doctor writes a prescription for a barbiturate, which multiplies the effect.

The person is depressed, and the drug takes a person down, and down, and down. The person gets addicted to the drug, and has to continually use that drug.

Mrs. FELDMAN. That is it. You cannot quit, once you are on, because of the very nature of the drug. Then, of course, you go into combinations, if you have a drink, and no one knows the effects of the individual's body chemistry either. So you are on a merry-go-round there.

Mr. LELAND. It seems to me that I remember about 10 years ago, when I was in pharmacy school, as a matter of fact, I heard over and over again how society or our culture is becoming addicted to medicine or to drugs by way of promotions on TV of OTC—over-the-counter drugs—by way of what we were talking about earlier, the doctors writing the enormous number of prescriptions.

Then it got to be somewhat of a law from that time until now in the overall concern for the problem, except that just the other day the new head of the FDA said that America is a drug induced society. I was interested because those were the same words that I had heard a few years ago.

I would like to ask you one specific question.

Mrs. FELDMAN. Certainly.

Mr. LELAND. You have dealt with young people and older people, I presume, using Valium, barbiturates and other drugs that tend to be downers.

Mrs. FELDMAN. Yes.

Mr. LELAND. Have you encountered any problems of people who use amphetamines?

Mrs. FELDMAN. Oh yes. I used amphetamines, that was one of my initial drug usages. Truck drivers, I found, live on amphetamines. Years ago, when I was growing up, it was like a joke, when you were studying, you would take amphetamines. Today, it is the diet routine. There are doctors who specialize in diet pills. Naturally, amphetamines are still on the street. I understand that there has been some restriction on them. But they don't care about them as much as they do the sedatives and the tranquilizers where there does not seem to be much of any restriction.

The amphetamines are still there. Ask any fat person who has gone to a doctor, somehow they are taking amphetamines.

Mr. LELAND. Are you aware of the fact that amphetamines do not serve as a drug for any particular illness or discomfort, other than obesity, and obesity is really not cured by the amphetamines themselves. The obese person who uses the amphetamines becomes addicted to the amphetamines. The amphetamine is what is called an anorexic drug. It cuts the appetite, it keeps the persons from wanting to eat much. Then once the person is off the amphetamines, he or she wants to eat more and more, and becomes obese again. Therefore, the drug serves no real therapeutic effect.

Mrs. FELDMAN. You are right. As far as I know, amphetamines is just another one of the killers floating around.

I remember that this was one of the components of one of the first drugs that my ex-husband offered me. I started using it with

the idea, "One makes me feel so good. Look at all the things I can do and say. So I will take two to make it even much better."

Now I look at myself, and I can do 10 times more, because there is always that after effect of the drug, the down effect, when you stop, which makes things that much worse. Amphetamines is a very dangerous and useless drug, I agree with you, and it serves no purposes. Why the hell it is out there, I don't even know.

There was a time when it was considered a drug of choice before the psychotropic drugs, but now we have different kinds of drugs.

Mr. LELAND. We have Ritalin now which has taken the place of amphetamines.

Mrs. FELDMAN. Yes. I understand that now it is used a lot. The thing is that now Elavil is now becoming a drug that can be abused, too. The doctors who have become scared a little bit by Valium are now writing prescriptions for Elavil. Now those are out on the street, too. So there is a whole problem going on.

What I think needs to be done in this whole area is educating the public out there that you can be in trouble. You don't have to go and just take a prescription because the doctor prescribes it. You have a right to question. You have the right to look at what alternatives, and that you should look at alternatives. You are not going to find the help you need in a pill.

I think we need to contact the recipients of those 45 million prescriptions of Valium, and offer some help, find out if they are really in trouble. I think that it is going to be a problem pulling a lot of these people out of the closet, because there is no resemblance to your stereotype drug abuser.

Mr. WAXMAN. I am going to recognize Congressman William Green. Congressman Green is much more knowledgeable than I am about the programs here in Manhattan, and is a strong advocate of Federal support for those programs.

Mr. GREEN. I want to thank you very much for inviting me. I serve on the Banking Committee, and yesterday we had hearings on the financial aspects of the illegal drug traffic, particularly the very large cash flows through the Florida banks, and the lack of action on the part of the bank regulatory agencies in trying to stem this flow to South America, which is dealing in the illegal drug traffic. Today, we are discussing another aspect of the overall problem.

I apologize for coming in late, but I had another meeting that I had to get to.

You may have covered this, but I have some impression that some doctors approach the drug problem in a rather sexist in the way. There is a tendency to start giving prescription drugs to women in cases where with the same symptoms, they would not give them to men.

Mrs. FELDMAN. Yes.

To start with, the number of women who go to doctors is much higher than the number of men. So we start with that premise, it is part of it.

I think that we still have a lot of old fashioned beliefs left in this society about a woman's capabilities. It is allowable for a woman to say that she is upset. It is allowable for a woman to say that she is under stress. However, it becomes a nuisance when people don't

want to hear this, and the doctor is going to shove a pill at her. I think that that is a part of the problem.

Man is expected to be strong. He is expected to be able to handle stress. You would sort of laugh off, "I am under stress." However, there are a lot of men in trouble out there as well as women. But I think that this is part of the sexist approach. Of course, where you see it so much is in the ads in the medical journals.

There was one ad of a woman in the shape of a chair for the permanent fixture in your office. Now that is derogatory. There was another ad of a woman shown as a puppet, limp, and then the strings and Valium give her something to float on air. There was another one of a wife having an argument. It does not tell you what the argument is all about, but give this woman the Valium, or whatever, and she is going to be a nice sweet wife again. God forbid that it should have been the husband who started the argument.

I think that it is a matter of attitude there. The stereotype, old fashioned belief of what a woman is capable of doing, or how a woman should be as opposed to how a man should be.

Mr. GREEN. I wonder if I could turn to the question of how you deal with a person when he or she is addicted. It has been suggested that the needs of these people could be better served by treatment at a community health center, or similar facility, rather than in a facility directly or exclusively related to drug abuse.

I wonder what your thoughts are on that.

Mrs. FELDMAN. I think that it can be addressed by anyone who has a basic feeling toward the concept of drug-free. If there is a community health center which has that concept, fine. If you are going to have a lot of doctors and psychiatrists floating around that are going to put their nose in, and start with the prescriptions, you are undermining whatever effect you can have.

Definitely it can be done, as long as that concept is adhered to. But I also feel that a program such as Daytop, which has followed that concept of drug-free, and takes into account the very special needs of these people, the need for privacy, is very important. I think that it can be done from both angles.

One of the first things that you are going to have to do for someone who comes for help is a screening as to the need for detoxification, that, of course, should be done in a hospital under the care of a doctor that really understands the problem. I am not saying that all the doctors are ignoring the problem. There are many out there who do understand it. Those are the prime requirements for that type of program.

Mr. GREEN. Thank you very much, Mr. Chairman.

I want to thank you again for convening this hearing in New York City. It certainly is most welcome, and I appreciate it.

Mr. WAXMAN. Let me ask you one question. Do you feel the charge is accurate that funds for the National Drug Abuse Institute ignore the serious drug abuse problems of women caused by prescription medicines?

Mrs. FELDMAN. I don't see anything happening to help these people concerned, if that is what you mean. I think that is where it had better go. You had better start doing something with education programs for the treatment of it. There is nothing that I know of.

Mr. WAXMAN. I am wondering, is Daytop Village an exception among treatment programs where they treat not just the street drug abuse problems, but also the problems caused by legal obtained prescription medicines.

Mrs. FELDMAN. I am not sure that I am with you, but we are working on a proposal right now to address this type of problem right here in Daytop.

Mr. WAXMAN. Would most middle-class women feel comfortable coming to a program like Daytop, or would they feel more comfortable going to an alternative treatment setting—such as a community mental health center—because of the negative image they have of drug abuse?

Mrs. FELDMAN. I have found that the majority of people out there really don't know about drug programs. You don't know about them until you are in trouble and looking.

We have an extensive family program. Many people are perfectly straight in coming in. Their original association is because of their children, but they are now coming in for help on their own.

So to start with the concept of Daytop has grown beyond just a drug program. It is a family program. It is a place you can get help. It is a place where there are people who will love and care, and it is based on drug-free. I think that is a big part and parcel.

Then, also, a program like Daytop could certainly do it, taking into account the need for privacy of project so-and-so based on Daytop. You have to take into account the special needs of these people, and that line of privacy would be required.

Someone who is going into a standard program, I see no reason why a drug program could not very well handle it. You just look at the special needs of the population you are dealing with.

Mr. WAXMAN. We provide moneys for drug abuse programs but I think a lot of people still think of drug abuse only in terms of heroin. I am wondering whether we ought to have a separate drug-free program to address the enormous health problems caused by drugs other than heroin.

Mrs. FELDMAN. Basically, I agree with you. After the drugs are out of the way, treating the whole person on both levels it what is needed. But this I have to say, your standard social workers, your counselors are not really familiar with the basic concepts of the drug-free program, and I think that that is an integral part of the treatment, to teach that you can live without a drug, and that prescribing drugs is ignoring the inherent capabilities of people to achieve. That is why I consider that kind of concept as a must.

I look at it, really, as a symptom of the whole country, when the most widely prescribed drug is a tranquilizer. At that level alone, I think that we have to address the problem. However, we do it, it has got to be looked at because we will become a mind controlled society that way, and I don't think that we want that for our country.

Whatever you do, and however you do it, it has got to be done. It has got to be done by people who understand what the problem is and how to treat this person.

Mr. MURPHY. The previous panel bears that out. I asked each one of them if they had gone to a psychiatrist, or to a mental health

program, and they had been, but they went to a program with people who did not understand the drug problem.

Mrs. FELDMAN. That is right.

Mr. MURPHY. They might have been prescribed a drug.

Mrs. FELDMAN. That is right.

Our housewives and so forth may not want to associate their problems with addiction, or drug abuse, but it is. I could not recuperate, I could not be rehabilitated until I had to accept the very painful fact that I, too, was an addict. My having anything to do with those? But I was an addict. Until I could admit to that, I could not take the steps toward recovery.

So I think that that is the basic principle, Mr. Murphy, it has got to be done by people who know how to handle and understand the concept of drug-free. Sometimes it can be a rough concept to understand the way our television shows go, "Take a pill and feel better."

The whole idea of taking something to feel good, where in the world did we get the idea that we must feel good every minute of the day. Life is not made that way. You have to learn how to live, how to cope with life. But there is nothing written that says that you are going to feel good every minute of every day. So it is a phony world.

Mr. WAXMAN. Mrs. Feldman, you have been an excellent witness. We want to thank you very much for being with us today. You have made some very good points that are going to be very helpful to us in our work.

Mrs. FELDMAN. Thank you very much.

Mr. WAXMAN. I would now like to call upon two distinguished individuals to testify as a panel. Our host, Monsignor William B. O'Brien, president of Daytop Village; and Dr. Harold L. Trigg, clinical chief, methadone maintenance program, Beth Israel Hospital are nationally recognized experts in the field of drug abuse. The subcommittee is honored to have them with us this morning.

STATEMENTS OF MONSIGNOR WILLIAM B. O'BRIEN, PRESIDENT, DAYTOP VILLAGE; AND HAROLD L. TRIGG, M.D., CHIEF, MEDICAL AND PSYCHIATRIC SERVICES, METHADONE MAINTENANCE TREATMENT PROGRAM, BETH ISRAEL MEDICAL CENTER

Monsignor O'BRIEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Monsignor, we have your prepared statement, and will put your complete statement in the record. We would appreciate it if you would summarize your statement so that we could get on to a discussion, which is always so helpful to us.

Monsignor O'BRIEN. I followed the discussion prior to this, and I think that there are some interesting things which focus on what the therapeutic community actually says and does.

In mental health, and Dr. Trigg is a psychiatrist, there are three basic levels, psychoses, which is mental illness proper—when we were growing up our parents thought that everyone was crazy, and maybe they were right.

There are three levels, psychoses, which is mental illness proper; neuroses, and the character disorder. Psychiatry, basically, has made measurable inroads in terms of impacting upon the psycho-

see, which is the fantasy level. Some wit said, and I think that Harold Trigg wrote it, "Psychotics build castles in the sky, neurotics hide in them because they are filled with anxiety, and the character disorder refuses to pay the rent."

When you are dealing with the character disorder, you are dealing with the alcoholic and the addict, the drug abuser. Four percent of them have, in addition, a neurosis or psychosis, and that is one of the basic reasons why it is a totally different ballgame.

We talk about treating them in mental health centers, and things of that sort. They do that in Stockholm, Sweden, and as some of you might know the problem in Sweden is amphetamines only, or at least up until the last year-and-a-half.

We have the character disorder being treated on the professional model, and we have psychiatrists giving them chemicals to deal with their problem, when their problem is chemicals.

The character disorder, basically, is the emotional baby in the adult's body. Just to give you an example, especially in the middle-class home, when the child travels through the family, whether the parents know it or not, there must have operative a process that the pedagogues call maturation. Maturation, in the simplest terms, is the successful transference from parental-imposed controls, which is: You will be in at 9 o'clock, you will walk the dog, you will take the garbage out and clean your room, to self-imposed controls on an increasing scale through the instrument of challenge.

For one reason or another, our generation that grew up in the depression, we did not have a nickel in our pocket, we said: "I am going to give my kid the things that I did not have." The net effect of that was that it militated against the successful navigation of that process called maturation, and the child was given things rather than challenged, so physiologically or chronologically emerged to be 18, 19, 20, but had stopped growing emotionally and was locked in at 8 years old.

An 8-year-old infant cannot handle the stress of the adult world at 20, and so has to run away from it. That is what the kids were saying, and that is what the young man from Beth Israel was saying. He or she had to run away from it, and used drugs to block out the stress of responsibility.

We have been saying for many, many years, "Stop chasing the drug. Deal with the person behind the drug." I know that the President now has that in his Federal policy for 1979, that the Federal Government will focus on the person behind the drug.

The therapeutic community deals with the person behind the drug. We have been dealing with poly-drug use, and everything from heroin to Aqua Velva, happily, since we started. We basically do that process of maturation over again. That is all that we basically do. It is more in the educational zone than in the mental health zone.

We put in parental imposed controls again, and we say to them: "You don't have a drug problem. You are a baby." They say: "Why?" We say: "When you were small, your mother would not let you near the street because you might be hit by a car. Who would shoot a needle into their arm, if they don't know what is in the stuff? Who would pop a pill in their mouth, if they don't know what it is going to do to their system?"

So we basically do that over again, we do the transference. This is the reentry house, where they have been up in the country for a year, and they come in here, and we introduce stress deliberately to see whether that whole process of maturation, which was done over again upstate, is working. This is basically what this house is.

Congressman Green will be happy to know that it was dedicated in 1903 as the Republican Club.

Mr. WAXMAN. It is being rehabilitated.

Monsignor O'BRIEN. Basically, this is what we do at Daytop. We basically do the process over again.

We are dealing with two characterological models. One which comes out of the deprived setting, where there is an absence of love, and no discipline, mostly because one of the parents is gone, and the other is from the upper-class/middle-class family, where there is not an absence of love, but the wrong kind of love, the consuming kind of love, giving the child everything and no discipline.

We have two treatment practices. We are not the answer to everybody's drug problem. I think that Dr. Trigg would agree with me that there are probably seven or eight characterological patterns out there that need seven or eight responses.

Basically, the treatment model that we have put down the road is based on the recognition that it is the youngster behind the drug that needs the treatment, and he does not need it in terms of his chemicals.

[Testimony resumes on p. 55.]

[Monsignor O'Brien's prepared statement follows:]

STATEMENT OF MONSIGNOR WILLIAM B. O'BRIEN, PRESIDENT, DAYTOP VILLAGE

We at Daytop find ourselves both honored and heartened to have this Subcommittee of the Congress under our roof this morning. This field-hearing under Chairman Waxman and ably assisted by our own Congressman John Murphy, indicates to all of us in New York's treatment sector that the Congress of the United States is concerned enough about young people and the peril of drugs to take leave of their vaulted chambers in favor of going to the information source. This makes good sense and we hail the wisdom of this decision.

Perhaps, as a prelude to my narrative, you will accept my own personal assessment that the precise converse of this course of action by government over the years has contributed in no small way to the measurable reduction of treatment impact. You are looking at the only permanent factor in this Town's battle against drug abuse. It is those of us in the voluntary treatment sector who have provided stability over 16 years now in New York while we have been compelled to dance to the shifting tunes of 16 governmental chieftains. I begin to feel like the miner in the folk song, "Sixteen tons and what do you get, another day older and deeper in debt." The debt unfortunately becomes an undischarged obligation to our youth.

Sixteen years, sixteen leaders and sixteen visions of how to cope and all the while kids are dying. Federally, we have had the 4-horsemen of Yolles-Brown-Dupont-Pollin; Statewise it's been 6 generals: Pierce-Luger-Jones-Cagliostro-Klepak-Martinez and, not to be overlooked, the Big Apple's own 6 Drug Commissioners: Ramirez-Baer-Finney-Chase-Hornblass-Bihari. We moved over these 16 years from chasing the dragon, to chasing the mugger, to chasing the drug - and now to chasing the dollar. It's no small miracle that we were able to keep faith with our responsibility to the tragic young lives of this Town.

While we recognize the inevitability of changing bureaucracies, we also recognize the companion difficulties of staying-on-course while a new leader on one or another of the three regulatory levels monitoring our treatment journey rushes to place his personal stamp on the field. For example, Daytop's original community-based day-centers had a mandate from OEO in 1968 to assess and move, on the root causes of community decay, while rekindling personal and neighborhood pride toward helping people to help themselves. This effort rested at the very center of prevention efforts. It focussed upon the early signals of a neighborhood's decay which, unless arrested, would mushroom into abandoned buildings, refuse-strewn lots, crime and drugs. After considerable headway was made on the lower eastside and in Bedford Stuyvesant especially, Daytop's Outreach Centers in 1972 were ordered out of the people/neighborhood rescue-business into ambulatory treatment and prevention activities with its funding shifted to NIDA. They continue in this form to the present, dealing with neighborhood youngsters as young as 11 and 12 years. Moreover, another illustration of the governmental boilerplate occurs when we move into the schools, youth centers and on to the streets in a massive effort to engage the youngster who is toying with truancy, acting-out behavior and now-and-then reefers, and we are told that these primary prevention energies cannot meet the bureaucratic definition of prevention. Once a youngster is motivated and engaged by our teams (no matter how young) in changing his life-style, it becomes <u>intervention</u> and that's treatment.

Let me share with you a painful but not atypical experience that our agency endured. In a past fiscal year, the red flag of accountability was waived, the Addiction Services Agency, our municipal chieftains, engaged the prestigious firm of Haskins and Sells to audit our books.

The auditors soon appeared at Daytop Village and began their scrutiny. A problem surfaced: they kept tripping over another team of auditors performing their regular duties. The fact was that Daytop's accounting firm was also Haskins and Sells, a highly competent, but not eleemosynary institution. ASA was paying a firm to audit their own work.

Let me remind you that these muddled lines of authority have been in existence for over 16 years. I am somewhat heartened by recent efforts within the State Division of Substance Abuse Services under strong leadership to meaningfully exercise its watchdog function.

We have made some headway in moving towards a viable partnership between government and the private sector. The impact of treatment in New York State is the highest in the nation.

There is no question that we could have serviced an additional 40% of the youngsters we were restricted to over the past decade if the monies, which were fed into the accounting industry were ploughed back into treatment.

All this is a departure from the body of my testimony and I beg, the Committee's indulgence for this liberty. As the vagaries of 16 governmental leaders over 16 years impact upon the young people of this Town, we are prompted to suggest that it might be the time for an innovative top-level "Manhattan Project" for this metropolitan area. A non-government authority with the mandate to address the drug epidemic across the region, charted and funded by government but peopled by concerned, experienced community leaders. This summit-project makes sense as we approach the '80's.

A review of the past decade of the drug scene in this Town represents an intriguing narrative.

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Young America of '69 woke up to the excitement of man's first footprints on the Moon (they were Neil Armstrong's). There was a recognizable surge of national pride in this phenomenal achievement. Heads were spinning with double messages, however. Timothy Leary for 6 years now had been exporting (from the mid-Hudson Village of Millbrook where Daytop with design subsequently positioned a treatment center) the message of "getting high and dropping out" of all this hassle - but '69 saw Woodstock and its symbol of ambivalence.

Heroin continued to be the drug-of-choice through the '60's and into the '70's, though the clientele was changing drastically. From Daytop's outset (1963) and through her first five years, the name-of-the-game was hard core, ghetto heroin addiction. Middle class involvement centered upon Doridane, Tuinals, Seconals mostly - all barbiturates. By '69, however, the shift was underway and heroin was emerging as the middle class "in-thing" on Westchester Avenue and Morris Park in the Bronx, in Brooklyn's Bay Ridge and Bensonhurst, at the Ferry Slip at Port Richmond.

1970 saw young people fall at the end of a national guard rifle at Kent State. Expanding the American troop presence from Vietnam into Cambodia that year connoted a widening of the prospects of carrying a gun in a questionable war. 1971 brought a glimmer of hope with the opening to Peking and the great land-mass of China. 1972 saw the bloody outrage of the Munich Olympic games and 1973 Watergate. All these had a telling effect upon the young and in an unforseen way helped to shape the course of the copping-out pattern via drugs among the young. The geometric growth of drug addiction and abuse in the Bronx, Brooklyn and even Scarsdale had some revealing fall-out. One could no longer hold that it was "those people" from the ghetto who fed the plague. It was the children of our own neighbors, our friends and our own kids. And among them, the median age began dropping and

dropping. Marijuana was as common as coca-cola and yoo-hoos at the high school basketball game. Arrests were noted in screaming headlines in the local newspaper.

Then something happened that never occurred in the past (especially in the 50's and early 60's when 61% of Harlem's youth were using drugs and no one cared). Important people from affluent communities began to feel the embarrassment of a son arrested for drugs. Instead of taking a hard look at the youngster, his problems and the family unit itself, they began to submit to the specious rationales of their own kids; i.e., drugs should be legal; it's nothing more than the highball in your hand; cops should stop arresting; in the interim, I'll give him the money to make "a buy" rather than have him arrested for burglary and stain the family name.

Presidential elections were rolling around in'72 and, in preparation for same, a vast campaign was undertaken many months before to roll back the drug plague afflicting our young people. There were three White House Conferences on Drug Abuse alone. But, the hidden agenda was crime-on-the-streets and the swift reduction thereof which could ring bells at the ballot box. The massive Rockefeller Program had been locking up junkies since '66 in nothing more than carpeted prisons, totally devoid of any true treatment construct. Parallel to that, New York was treated to the most outrageous brand of Methadone Maintenance in the nation. It is difficult to comprehend for example, that while Chicago under Doctor Senay was fielding a promising Methadone effort (as were some eminent, private New York treatment professionals in places like Beth Israel and Bronx State) with low-dosage (40 mgs.-maximum) and goaled toward a drug-free state, New York

City Methadone was scaled for high-dosage only (beginning at 80 mgs.) and without any drug-free goal setting. Compounding the problem were many proprietary clinics which took some while to close down as Methadone profiteers. Clients soon discovered that heroin was effectively blockaded on minimum dosages of Methadone and sold the excess. By the end of '72, Methadone flowed like water on the streets, matching heroin in popularity. At this time, Daytop admissions revealed that 60% had street Methadone as the primary drug of abuse.

There was a silver-lining to all of this. Treatment people in New York by late '73 developed an awareness that we were in this together and that we should close ranks if we were to help this Town's kids. Drug-free Centers became increasingly conscious of the high, drop-out rate on the early end of treatment (initial 90 days) and of the imperative to adapt professional standards of operations in both clinical and administrative zones. Methadone Maintenance Directors recognized the problems of clients shifting to Methadone-plus (whether pills, alcohol, cocaine) and saw the need for 24-hour treatment settings for more than a few clients. Out of this mutual-need discovery came shortly thereafter the city-wide Greater New York Coalition of Drug Treatment Directors (inspired and headed by our own good friend and colleague, Doctor Harold Trigg at Beth Israel) as well as the Association of Voluntary Agencies on Narcotic Addiction under Reality House Sydney Moshette and Therapeutic Communities of America, Inc./New York Regional Chapter under Samaritan's Don Russakoff. This phenomenon is unique in the nation. Such consortia has reaped dividends in a sophisticated referral construct allowing for the client to be serviced by the agency most responsive to his/her needs.

Parallel to these developments, a revolution in treatment was underway locally. Drug-free, self-help therapeutic communities across the City and State took root, offering more and more young people the hope of rehabilitation. New York (with California) developed the heaviest concentration of drug-free alternatives. I speak of a host of Daytop's colleagues, structured for the wide range of socio-economic and ethnic needs: Phoenix House, Odyssey, Project Return, Samaritan, Veritas, Renaissance, Reality, J-Cap, Promesa and a host of others.

1974 saw a President resign his office; 1975 the emergency evacuation of the Embassy in Saigon and 1976 the Bicentennial. The growing vitality and diversity of the drug-free treatment network in New York over these years represented a fortuitous development. The nature of drug abuse had continued to evolve by the mid-70's from the hard-core, heroin addict with a criminal background of the '60's with a median age of 22 years to polydrug abuse (PCP, Butyl Nitrate, Sedatives, Cocaine, Chronic Marijuana, Illegal Methadone) with a median age of 24 but with an alarming drop in the age of exploration from 16 years to 9-10 years. This trend continues to the present. By focussing in on the symptom (heroin) rather than on the person behind the drug, how much of a role the governmental planners played in spreading the problem laterally to other substances, I will leave to subsequent research.

Mr. Chairman and members of the Committee, you find yourselves today holding this Congressional Hearing in a Therapeutic Community, Daytop Village. May I tell you a little something about the TC, its treatment approach and about Daytop.

Born in the late 1950's amid the ruins of every other effort to deal with the drug addict, the Therapeutic Community Movement has revolutionized America's mental health delivery system over two decades. There are 577 TC's from Hawaii and Alaska to New England and Florida. New York alone has 52 with neighboring New Jersey and Connecticut with 26 each. We currently head the nationally-recognized consortium, Therapeutic Communities of America, Inc. with offices on Chicago's Michigan Avenue at Gateway House. TCA has provided the forum within the drug-free sector for sharing, training, staffing as well as for setting standards and goals.

Rejecting the prevailing premise that the addict's problem is solely physiological and, hence, his treatment must be pharmacological, TCA contends that addiction is a problem psycho-social and complex. The solution is also complex, dealing with the total human person and etiological factors which are at once social, ethical, psychological, physiological, cultural, theological and sexual. There are just no simple answers.

It proceeds from the premise that man is not fragile - he can and should be confronted with his condition and challenged to grow into maturity and responsibility. This is achieved via a caring but demanding 'family group', a peer-group therapeutic community. Further, the TC impresses upon the young drug abuser that "only you can do it but you cannot do it alone".

833 young Daytoppers in 10 scattered treatment centers (526 in residential treatment; 307 in 6 days-a-week ambulatory treatment) has positioned Daytop as the largest as well as the oldest TC in the nation. Synanon alone preceded us and, as most of you know, has long since left this field in favor of a controversial life-style cult. Currently, we exceed even

Synanon's population figure.

Treatment in Daytop begins with admission to our Induction Center down this street at 9th Avenue. SIR (meaning Screening Induction and Referral) is a 10-day screening setting where medical, psychological, social service and legal analysis is completed, enabling the Staff to reach a sound decision as to where this client belongs. SIR may refer the client to Daytop residential or ambulatory treatment centers, to a sister-TC to Methadone Maintenance, to a psychiatric hospital or to traditional, one-to-one therapy. The emphasis is on the client's need profile.

Once assigned to Daytop residential, he/she boards a van to one of our sprawling centers in the Catskills or Berkshires for a period of one year. Here is where the 'miracle' takes place - where the role-model of the ex-addict, where positive peer-pressure to change, where values and concern, where responsibility and challenge - all serve to rebuild the young person. After that year, the Daytopper arrives at this building, the Re-entry Center for the final 6 months. 123 residents live in this building currently; though the 85% already employed outside render this Center rather quiet during the day hours. The emphasis in re-entry is on handling stress and on tooling-up for a productive, responsible life-style in the community. Schooling is a primary emphasis. Daytop's own miniversity (funded by NIDA) with Brooklyn College has created in Re-entry especially but across the program an intensive interest in undergraduate and graduate work. As a part of Re-entry, residents are guided in positive social relationships, in cooking and apartment decorating, in employment skills, in money-management and budgeting, in exposure to the arts. They move in Re-entry from phase to phase, culminating in living and working outside but returning to evening groups twice weekly. After a year in this final stage and with signals

of positive performance from employer, college dean, relatives and friends, he/she is issued Daytop's coveted graduate certificate.

The other Daytopper, however, was sent by SIR to one of the 5 Ambulatory Centers. He/she is usually younger and much less dysfunctional. The program in the Ambulatory or Outreach Center is day-long, 6 days a week. The treatment plan is based on the TC construct but angled for the young person's particular needs.. All treatment stages are all at the same center. It is important to note that Daytop places a value on keeping the young person in his family, in his school or in his job and only refers to residential treatment when family or neighborhood environment is totally negative and irreversible.

And that brings us to a final dimension of the Daytop process - family therapy. These sessions are held weekly at the Outreach Centers and at this Re-entry Center. The parents or husband/wife of the client is exposed on a weekly basis both to groups and one-to-one therapy. This is, perhaps, the most ambitious part of Daytop - with near a thousand relatives in therapy each week, viewing themselves as they are and growing to be better people, better parents, better spouses.

Out of our Board's commitment to the young wherever they are found, Daytop over these years has helped design, train and/or staff 92 programs in the United States and Canada and 17 abroad. We are not bent on empire and refuse to operate any outside of the New York region. However, we will continue to help any community to help itself with its own drug problem. In such disparate zones of the globe as Malaysia, the Philippines, Italy, Great Britain, the Daytop model of recovery is operative. In the West German Federal Republic, 12 Centers carry the Daytop name.

Daytop is funded by the State of New York (Division of Substance Abuse Services), by federal funds (National Institute on Drug Abuse), by Westchester County (Community Mental Health Board) and third party payments. The annual budget is 5.5 million dollars. Our annual per capita cost is $2,400 for day-care treatment; $7,081 for residential care. These figures represent the bargain of the century. When one considers that 63% of Daytop's roster would be otherwise in a jail cell at a cost of $26,400 a year and another 16% in a health facility whose medical beds cost $54,750, we're doing more to compress the inflationary spiral than most. In addition, the aggregate taxes currently paid by Daytop graduates annually greatly exceeds our own funding level of 5.5 million.

There is no question that even given the vagaries of funding emphasis, the federal commitment of one billion dollars over the past decade has produced both measurable movement as well as the most sophisticated response network in a health crisis zone in the world. NIDA took a long time to recognize the drug-free alternative and a longer time to see validity in treatment programming over innovative, oftentimes specious research experiments. But in 1979, NIDA is right-on-target and will be even more effective once the agency recovers its full discretionary powers after its recent period of seige. I am not denigrating the scrutiny applied by the Congress and the media. I am pointing to the checks-and-balance mechanism consequent upon such disclosures and put in place by the former Secretary as procedures which largely paralyze movement and place NIDA less responsive to us in the field.

Is the existing treatment service network adequate? I have no problem with this question: NO! New York treatment agencies are jammed. In Daytop's case, we are 2X over our funding mandate and have a waiting list.

We could increase our residential capacity in existing facilities by another 250 today if the funds were available. Across the city and country, therapeutic communities are reporting the same story.

Where should our restricted resources and energies be applied in the 80's? My lights lead me in the following directions:

1. Polydrug abuse will pervade the 80's. Utilize the seasoned treatment network for tooling-up a response.

2. Emphasis should be given to calling on the seasoned, effective treatment agencies for purposes of testing new modalities for these groups:

   - women
   - adolescents
   - prescription drug abusers
   - family therapy
   - vocational education candidates
   - polydrugs plus alcohol

   Analysis tracking and selection should follow. These problem zones are already pressing.

3. Federal Management needs streamlining and be open to the consultation with and utilization of the resources in the field - the treatment and prevention leadership.

4. The effective prevention models in 1979 can be tabulated on one hand. NIDA should be enabled to field an array of prevention models goaled for the varying populations: childhood, pre-adolescent, young adults.

5. Public awareness and public education is a zone which has been greatly neglected. Contrariwise, the Studio 54's and the disco scene generally is speaking directly to the values of American life and our sincerity in challenging destructive behavior when it involves the prominent or the wealthy.

Youth hungers for values and demands consistency on the part of the adult society. I don't think that this is too much to ask for!

Mr. WAXMAN. Thank you.

Dr. Trigg, would you like to proceed, and if you would also summarize, it would be helpful. Your complete statement will be placed in the record.

STATEMENT OF HAROLD L. TRIGG, M.D.

Dr. TRIGG. I would like to thank the chairperson, Mr. Waxman, and the distinguished members of the subcommittee for permitting me to testify before you today.

I would also like to thank Mr. Ripley Forbes for getting me sufficiently organized in several telephone conservations so that I could show up at the right place and at the right time.

I would like to extend my own personal tribute to Monsignor O'Brien for taking uncommonly good care of me now, and hopefully in the hereafter.

That is my hereafter, and not his.

As someone closely associated with the methadone program since the inception, starting with the research beginning in 1964, I have been called, I hope affectionally, the biggest pusher in New York City. I hope that Monsignor is not embarrassed that I am in a drug-free facility with that sort of reputation.

I have previously submitted a summary of testimony to Chairman Waxman, essentially commenting on the activities and services provided by Beth Israel Medical Center's methadone maintenance/treatment program, which you will find in a brochure. I hope that all of you have copies of that.

In addition, I have submitted comments on training for the changing drug scene in New York City in the past 10 years, essentially commenting that the drug of abuse of choice now seems to be something called placydil, which is a sedative/hypnotic.

I also talked briefly about the role of methadone in drug abuse treatment, and I would like to take this opportunity to make a correction on page 2 of my letter to Chairman Waxman. The second line from the top, the word "many" should be deleted. It does not make sense in that context.

In my final point, I make reference to what I thought to be more Federal focus in terms of drug abuse programs, and that is, I certainly appreciate the necessity for government agencies exercising regulatory functions, but there can come a time when the monitoring becomes so excessive that the treatment personnel are more engaged in compliance than they are in training.

Finally, before the discussion period or the question period, I would like to point out particularly to Congressman Murphy that in the Staten Island Advance of Monday, June 18, 1979, there is an entire article devoted to my patient, whom you saw earlier this morning, Terry Pinder, and I think that you have a copy of that.

I am sure that he would be very happy to have you shake his hand at the end of this, Congressman Murphy.

[Testimony resumes on p. 65.]

[Attachments to Dr. Trigg's prepared statement follow:]

Beth Israel Medical Center

METHADONE MAINTENANCE TREATMENT PROGRAM: An Overview

Since 1965, Beth Israel Medical Center has operated the largest Methadone Maintenance Treatment Program (MMTP) in the United States under voluntary hospital auspices. It was based on, and still follows, the principles for the treatment of heroin and other opiate addictions with methadone outlined by Drs. Marie Nyswander and Vincent Dole. It was through their pioneering research efforts at The Rockefeller University in New York City that methadone was found to be a valuable tool for the effective treatment and rehabilitation of heroin addicts.

Enrollment in the Methadone Maintenance Treatment Program is voluntary. Beth Israel Medical Center currently treats more than 6700 methadone maintenance patients with over 900,000 visits annually in outpatient units serving four boroughs of New York City. More than 4500 Beth Israel MMTP patients (over 65% of the enrollment) have been in treatment for two years or longer. One key factor in the success of the Program is the length of time patients remain in treatment. Approximately 80% continue in active treatment for at least one full year after enrollment.

Beth Israel has as its treatment goal the rehabilitation of the patient. It is well established that a majority of patients who leave addiction treatment — whether methadone maintenance or drug free — return to heroin or other substance abuse with a concomitant erosion of rehabilitation gaint. Because of the chronic nature of opiate addiction, patients generally are encouraged to remain in treatment in the Beth Israel MMTP. Although detoxification from methadone may become part of a patient's treatment, it is not a universally achievable — or appropriate —objective for everyone. All possible medical and psychological support, however, is given to patients who wish to detoxify, and at any given time approximately 10% - 20% of the patients are

on a detoxification schedule or in an after-care phase subsequent to detoxification.

Program Organization and Objectives

Beth Israel Medical Center pioneered the concept of providing methadone maintenance treatment in the community. To this end, patients attend community based clinics in Manhattan, Brooklyn, Queens and Staten Island. Back-up medical services are provided directly by Beth Israel Medical Center or through formal agreements with major hospitals and medical centers in the New York City area, with which we have clinics. These agreements provide for medical,pharmaceutical and psychiatric support services to patients. Each individual clinic cares for from 150 to 350 patients, and maintains a professional staff of physicians, physicians' assistants, registered nurses, graduate social workers, vocational rehabilitation counselors, and general counselors. With the belief that methadone maintenance treatment should be available to all narcotic addicts who voluntarily seek this approach as a step toward long-term rehabilitation, Beth Israel Medical Center MMTP adheres to the following principles:

—the provision of appropriate pharmacological support through individual doses of methadone taken orally on a physician's prescription in order to eliminate the craving for heroin and other opiates, and,

—the provision of effective supportive services to all patients who want and need assistance in the following areas: social services, mental health, vocational rehabilitation, education, counseling, and socialization to enhance the functioning of patients and to provide them with the skills necessary to lead a socially productive and personally satisfying life.

Funding and Accountability

The Program receives most of its operating funds through third party reimbursement, primarily Medicaid. Patients who are ineligible for Medicaid are billed directly for their care on a sliding fee scale. In addition, the New York State Division of Substance Abuse Services provides funding to make up the difference between budgeted expenditures and third party reimbursement.

Beth Israel MMTP is approved by, accountable to, and strictly monitored by the following government agencies:

—Food and Drug Administration (Federal)
—Drug Enforcement Administration (Federal)
—N.Y.S. Division of Substance Abuse Services (D.S.A.S.-State)
—Department of Health (N.Y. State)

Among the requirements and monitoring activities of these agencies are:

—operating certificates for establishment of the Program and each individual clinic
—criteria for admission of patients
—stringent controls for the dispensing of methadone and safeguarding of methadone inventory
—statistical and financial reports and accountability
—defined staffing pattern
—urinalyses for evidence of possible drug abuse
—frequent on-site inspections
—patients' medication schedules
—strict criteria for the confidentiality of patient records and information.

To enhance community support and understanding of the rehabilitation process, the Program and each individual clinic has established cooperative relationships with local organizations including: community boards, police precinct community councils, block associations and merchant associations.

Vocational Rehabilitation

Beth Israel Medical Center's MMTP operates a vocational rehabilitation department staffed by professional rehabilitation counselors. Through the department, patients are encouraged to take advantage of resources and services to maximize their functioning level. This is accomplished through effective working relationships which the Methadone Maintenance Treatment Program has established with agencies that provide services in:

1. vocational evaluation and assessment
2. education
3. skills training
4. job placement and upgrading.

In addition, the vocational rehabilitation department offers recreational, avocational, and pre-vocational activities designed to develop self-esteem and a positive attitude toward the rehabilitation process. In turn, success in achieving these objectives enhances the effectiveness of services which leads to a fuller, more productive life.

The department also monitors those situations in which patients have been denied employment or training opportunity because of their backgrounds. Cases identified as discriminatory are referred for appropriate legal assistance. Cooperative relationships with other agencies are instituted in educating and informing the community of the capabilities of the methadone maintained patient.

According to our Program and other studies, social productivity increases markedly for methadone patients who remain in treatment. Social productivity is measured by rate of employment, education, vocational training or homemaking activities. At the same time, there is a sharp decline in arrest rates following admission to treatment — a substantial benefit to the community.

MMTP patients are engaged in many different types of vocations, including self-employment. A representative listing of positions held includes: proprietors of small businesses, TV and air conditioning repairpersons, executives, photographers, computer technicians, programmers, lawyers, teachers, nurses, salespersons, civil service employees, U.S. Customs inspectors, secretaries, professors, apartment building owners and superintendents, dancers, social workers, clerks, laborers, plumbers, and ambulance attendants. In other words, patients in the Methadone Maintenance Treatment Program *can* and *do* hold positions on all levels, in all types of work. In many cases, they have overcome tremendous obstacles to obtain or maintain their jobs.

Summary

Methadone maintenance has proven to be a major treatment approach in the effective rehabilitation of narcotic addicts. Its results have been unparalleled with respect to the retention of patients in treatment, increase in employment and educational activities, and the decline of criminality. Although it clearly is not the only answer, and is not successful with the entire addict population, methadone maintenance plays a vital role in assisting large numbers of heroin addicts return to a meaningful role in society.

Beth Israel Medical Center is a voluntary, acute care, non-sectarian hospital. No person shall be denied treatment at the hospital because of race, creed, color, national origin, sex, blindness or source of payment, except for the fiscal capability thereof. Beth Israel Medical Center complies with Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination on the basis of handicap.

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November 26, 1979

Henry A. Waxman
Chairman
Subcommittee on Health and the Environment
Congress of the United States
House of Representatives
Washington, D.C. 20515

Dear Chairman Waxman:

I am writing with reference to your letter of November 13, 1979 concerning testimony during the Subcommittee's upcoming oversight hearing on November 30th at Daytop Village in New York City.

1. Various activities and services provided by the Methadone Maintenance Treatment Program (See attached brochure). Add: 60% of our patients have been in continuous treatment for three years or more; 42% of our patients have been in treatment five years or more.

   The funding level as of April 1, 1979 is $12,900,000.00, of which $3,700,000.00 is supplied by New York State, with the balance essentially Medicaid reimbursement. A modest amount is derived from the direct payment of the patients themselves. The cost per year per patient is approximately $1800.00.

   In addition to the monitoring agencies listed on page 4 of the brochure, please add Medicaid and the New York State Office of Health Systems Management.

2. The changing drug scene in New York City over the past ten years. There has been an increase in abuse of controlled substances by teen-agers. This does not necessarily imply an increased incidence in heroin use, but is more reflective of an increased use of so-called "soft drugs." There appears to have been a decrease in the incidence of injectable amphetamine usage, but a continued popularity of sedative use. The current fad in sedative use is ethchlorvynol (Placydil, Abbot); diazepam (Valium, Roche); methaqualone (Quaalude, Lemmon), and the barbituric acid derivatives. This information is gathered from admissions to the 154 bed inpatient detoxification unit at the Morris J. Bernstein Institute which is a division of the Beth Israel Medical Center. During the calendar year 1978, there were 4,944 admissions to that unit for detoxification from various controlled substances, including heroin.

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OF THE CITY UNIVERSITY OF NEW YORK

3. The role of Methadone in drug abuse treatment.(See brochure for an overview). It should also be noted that: Methadone maintained patient's drug abuse rates decrease from a high of 58% in the first six months of treatment to a low of 22% after five years. These percentages include the abuse of alcohol. Overall, the drug abuse rate is twice as high among unemployed patients (34%) compared with working patients (16%). In terms of employment rate, 35% of the black patients are employed as compared with 49% of hispanics and 64% of whites. An additional 17% of patients are homemakers or in school. The overall arrest rate is 3%.

4. Suggestions for improving the effectiveness and focus of Federal drug abuse programs. The current reduction in length of time in treatment for Methadone maintained patients is probably in large measure attributable to Governmental over-regulation rather than maximum rehabilitation. Treatment programs waste much of their dollars complying with Governmental Regulations rather than treating patients. Governmental over-regulation also appears to discourage many prospective patients from entering into treatment.

I would like to take this opportunity to thank you and the members of the Subcommittee for the privilege of appearing before you.

Sincerely yours,

Harold L. Trigg, M.D.

HLT/bk
Enc.

Harold L. Trigg, M.D.
Chief
Medical & Psychiatric Services
Methadone Maintenance
Treatment Program

14 years in junkie's jungle world, methadone helps him make it alone

Mr. MURPHY. Dr. Trigg, there is a contrast between what you have said, and what Monsignor O'Brien has said. It goes to the basic contrast that exists in drug abuse, and the treatment of drug abuse.

You say that your methadone program will keep people on methadone for life. Is that true?

Dr. TRIGG. You could say that. I would like to enlarge upon it and say that although the patient whom you saw has been on methadone for 11 continuous years, there are people that we have been able to detoxify. Anybody who requests detoxification is certainly entitled to it.

So there is no coercion, but it is just that the patients that we have had on methadone who have gotten off, have had very poor success in remaining free. Why that is, I really don't know.

I would say that given the fact that drug addiction is a chronic disease, that it may, in many instances, require chronic treatment. I don't say that that chronic treatment necessarily has to be with a drug, but I think that the treatment does have to be chronic.

Mr. MURPHY. You have almost likened the methadone patient to the diabetic needing insulin.

Dr. TRIGG. Yes, sir, the diabetic, the epileptic, the hypertensive, any chronic disease, there is really no time limit on the medication. If he can get off, fine. I would just as soon if nobody ever suffered from any disease and, therefore, never required any medication.

Mr. MURPHY. Monsignor, perhaps you could describe the phases in Daytop. What you get coming in, and what is supposed to come out, within a given time frame?

Monsignor O'BRIEN. With your permission, I would just like to say that I would stress that there are still seven or eight character logical patterns out there. I think that Dr. Trigg would agree with me on that.

There are a number of those patterns in which the model that I describe to you does not apply. We refer from our induction center to Dr. Trigg for certain patients that methadone and his fine program, where he gives a lot of counseling and a lot of strength, can build and construct.

We refer people to his program because out of the patterns out there, probably half of them, but at least three of them that will yield only to good methadone maintenance. I would like to make that clear. It is not an opposing position that we take, but rather we compliment each other in more ways than one, but he is a Democrat.

In Daytop, there are two treatment methods. One is an ambulatory, and the other is a residential treatment model. The ambulatory is for the younger ones.

We prefer to keep the youngster still at home, in his job, or in school, rather than rip him out of those places. We only do that as a last resort.

We have in your district, for example, on Castledon Avenue, a Daytop ambulatory center, a day care center. We have the parents in at night to rebuild that family unit. That is where Daytop begins in an ambulatory setting. We put them through the same

process. They are there 6 days a week all day, and the family is in one evening during the week.

If the family damage is irreversible and if the neighborhood or the community damage is irreversible, and we can see that he or she is still consorting with negative people and using drugs, we, then, recommend strongly that they be put in residential. That is the way the process goes.

They, then, would go through the induction unit, which is on 9th Avenue and 40th Street, go through the psychiatric, medical, social service level screening, and be referred to Daytop residential upstate or to a sister therapeutic community. This might be a girl who needs extra emotional support, and we will send her to a therapeutic community that is heavily female, where there are female role models.

We reflect generally the ratio on the streets, 4 to 1, four males over each female, which is the addict ratio on the streets.

We might refer to Dr. Trigg. We might refer to traditional psychiatry, or to a psychiatric hospital.

If the youngster is referred to Daytop residential, he goes upstate for a period of 1 year, Congressman, and goes through the process of maturation in centers in the mountains, in Sullivan County and in Duchess County. Then, they return to this center.

There are 123 youngsters in this center. Most of them are out to work now, I suppose, and that is why it is so quiet. Here they go through the final process, which is reentry into the community. We expose them to employment training, to college at night, to cooking, decorating, money management, all those things necessary for a viable performance for the world outside.

Then we move them out to the final phase, where they live out and work out, and come into groups twice weekly. We evaluate them for 1 year, and then we move them to a graduate status.

Mr. MURPHY. It is a pretty lengthy process?

Monsignor O'BRIEN. It is about 18 months.

Mr. MURPHY. I think that the point that is made here is that, as you said, there are eight or nine characterizations of a drug abuser. Dr. Trigg can treat a certain portion of that characterization, whether it is just methadone maintenance, or whether it is tied in with counseling, and an eventual weaning from the methadone maintenance. And, of course, you have several categories that you move into the different programs.

Who coordinates all this at the problem level?

Monsignor O'BRIEN. We have to do the screening network. Chicago, for example, set up its central screening governmentally. They set up a central screening in which they put them out on tracks.

I think that it is important for all of us to remember that we cannot reinvent the wheel. If someone is treating this type of addict better than we are, we refer to them.

The other thing is. There was a comment earlier as to whether the prescription drug housewives should come into Daytop. I think that there is too much of a stigma to drug programs. I don't think that that person should go into the presently constructed community mental health center either.

I think that a model should be fielded with a different name, which can be exposed to the training in this process, where the middle-class housewife can be treated effectively.

I think, also, we are not the program to treat the aged, the elderly. I have worked with problems of the elderly many years ago in Jacksonville. I remember one where the major problem with the elderly with their arthritis was opening those new medicine bottles that you have to twist.

Out of our Brooklyn Outreach Center, our kids love what they are doing with the elderly, they are bringing lunches and dinners to the elderly, and it is good for them. We are not in the business of treating the elderly. That has to be another program. We cannot do all these things. We have to stay in the business that we are in, which is the youth drug problem, otherwise we are not going to be effective in any area.

Mr. MURPHY. Dr. Trigg, what is the annual cost of treating one of your patients?

Dr. TRIGG. It is $1,800 per year per patient.

Mr. MURPHY. Who pays that?

Dr. TRIGG. The State and medicaid. The funding level at the present time is $12,900,000 for approximately 7,000 patients, and out of that the State's contribution is $3,700,000, and the balance is essentially medicaid, with a very modest amount coming from patient billing, direct patient billing.

Mr. MURPHY. It is all outpatient work?

Dr. TRIGG. Yes.

Mr. MURPHY. The counseling courses, are they included in the $1,800?

Dr. TRIGG. All the staff salaries are averaged out in that $1,800 figure, the counseling, the social workers.

Terry has managed to get a master's in social work himself since he has been in the program. He is a supervisor of the clinic in Staten Island, so his salary is included in the $1,800 per year. Nursing, we have registered nurse positions, vocational rehabilitation specialists, all of their costs are included in that figure.

Mr. MURPHY. Monsignor, what is the cost of treating the Daytop inpatient?

Monsignor O'BRIEN. The cost of the inpatient is $7,081,000, which is an annual figure of course. For ambulatory, it is $2,740.

Interestingly, 68 percent of the people who are in Daytop would be in a jail cell for $26,400, or in a hospital, and the cost of hospital bed currently, and it is going up constantly, as you know better than I do, is $54,800. It is probably the biggest bargain of the century.

We are probably doing more to compress the inflationary spiral than most around. Wouldn't you say so, Harold?

Dr. TRIGG. Yes.

Mr. MURPHY. I recall that when Daytop started out all they ate was stale bread and limp lettuce, because they would go to the local grocery store and scrounge what got stale, and bring that back to Daytop and cook it. That is, of course, when it was at a minimum level of funding.

Monsignor O'BRIEN. That is true.

Mr. MURPHY. The General Accounting Office recently testified that our national treatment capability is significantly underutilized. They said that many utilization rates were inflated. Do you subscribe to that statement? [See p. 139.]

Monsignor O'BRIEN. There are two points on which I can speak. I am president of our national association, and then from our own situation here in New York.

For some reason, Harold might agree on this, this is the first summer in the 9 years that the population never had the usual summer drop. When the weather gets nice, the person who is starting getting his life back, or her life back, finds it very attractive to hit the streets, and try all over again. It did not happen this year, yet it happened every year for the last 8 years.

So the population for the last 13 months has held up very high. We are way over capacity. We are over capacity by 28, and we have a waiting list. We have not had that in 8 or 9 years. So the utilization levels in New York City, I think, are rather high. This is residential, now. Ambulatory is a different situation.

Now speaking as the president of our national association across the country, there are other sections of the country where utilization is low. For example, in California, where there are 94 communities, they have very low utilization mostly because these therapeutic communities are so tiny, and they should be moving toward amalgamation, because they don't have the technology for induction, or to set up referral mechanisms with hospitals, welfare centers, prisons, courts, and things of that sort.

So there is a problem in various areas of the country, but that problem does not exist in the high impact areas, as far as I know. I don't think that Los Angeles has the problem. I don't think Chicago has the problem. With New York, those are the three highest impact areas in the country.

Mr. MURPHY. For the July quarter 1979 New York State had the third lowest utilization rate in the country. The overall rate was 70 percent. [See p. 134.]

Monsignor O'BRIEN. New York State is the third lowest?

Mr. MURPHY. Yes.

In the drug-free program, we had 10,499 funded slots and only 6,533 utilized. The utilization percentage was 62 percent.

Monsignor O'BRIEN. Is that ambulatory and residential together? Ambulatory is low.

Mr. MURPHY. It is low.

Monsignor O'BRIEN. The residential is up to capacity but the ambulatory is low.

Mr. MURPHY. But, then NIDA uses a cost ceiling figure of $5,670 for residential treatment, and your cost is $7,000.

Monsignor O'BRIEN. The figure is $5,670, and the maximum is $7,000?

Mr. MURPHY. That is the NIDA cost ceiling on residential treatment. I think you said that your cost was $7,000 per patient.

Monsignor O'BRIEN. The Federal Government has set a cost figure which was set 5 years ago, and they never changed it with inflation at all.

So they are giving the residential programs the maximum figure, which is $5,000-odd. Our cost is $7,081. We are in constant discussions with NIDA to update their figure.

Mr. LELAND. Dr. Trigg, is there any evidence of long-term health risk to methadone maintenance?

Dr. TRIGG. Not in the scientific literature, sir.

Mr. LELAND. Not at all?

Dr. TRIGG. No, sir.

Mr. LELAND. What efforts do you make, or could you just describe briefly what it is that you do to try, at some point, to get people to stop using methadone?

Dr. TRIGG. Sir, the Federal regulations require that at least once every 2 years a note be made in the patient's chart justifying his continuation on methadone maintenance. We are in strict compliance with that regulation.

In addition, at any point in treatment, if a patient wants to try detoxification, I assure that he is given that opportunity. I don't feel that it is in any sense morally correct for me to insist that somebody stay on methadone just because I may be in favor of it. Even if he fails, he has priority in getting back in treatment immediately.

Mr. LELAND. Do you encourage people to try to get off of methadone?

Dr. TRIGG. If the patient has numerous complaints about things like feeling trapped in a system, or impaired mobility, he cannot get out of the country because he has to take a large supply of the narcotic with him, or his vacation is limited, or his wife does not like it, we say: "Fight it off."

Mr. LELAND. I understand that there is a greater influx of heroin from the Middle East now. Is that causing you any special problems; does it complicate your program in terms of the number of people who are going to need to try to cure themselves, or at least to find the alternative through methadone maintenance?

Dr. TRIGG. So far I have not seen any impact. If anything, it might cause a decrease in census if the stuff on the streets is good, and is not that more expensive than it was 5 years ago. I understand that it is not more expensive. But I have not seen any impact in terms of a long line applying to my intake. We have a waiting list, but it is fairly modest.

Mr. LELAND. Are you saying that it is not more expensive today than it was 5 years ago?

Dr. TRIGG. That is what I am told now, whether that is true or not, I don't know. If you look into my letter to Chairperson Waxman, Beth Israel Medical Center, aside from the methadone maintenance/treatment program, operates the largest voluntary detoxification service in the world—154 inpatient beds, plus 50 medical beds. Last year, we had a round figure of 5,000 admissions.

My data is simply based on those admissions. For example, if a guy comes in today, he asked: "Where do you get your heroin? How much do you pay for it? How much does it cost? Is it good?" That is really the only thing that I can really base it on. I don't have any chemical analyses to base it on.

Mr. LELAND. It is very interesting.

Just from a self-interest point of view, how do you go out and find people who really want to get off of heroin and get on to the alternatives?

Dr. TRIGG. We recruit aggressively, as it were. We don't need to at this point. The medical center is well known in the field of addiction, certainly in New York City, having been in business since January 22, 1961. We have the original methadone program. We have one of the original six methadone patients. The founders of the methadone program are officially on our attendance staff.

I think that former patients and present patients really do most of our public relations.

Mr. LELAND. Monsignor O'Brien, I really want to commend you for your part in this. I am not going to be able to stay, but I would like to come back at some point and look at what you have, and try to get a feel for the history.

I don't know whether you are familiar with any of the programs in Houston, but there is one program that is pretty significant, that is doing a successful job of doing basically what you have done. I certainly appreciate your efforts.

I am impressed with all of the people. I did not have the opportunity to hear all of the testimony, but some of the testimony that I heard was most impressive.

Monsignor O'BRIEN. Thank you, Congressman.

We have a program in El Paso. The program that you are referring to in Houston, is that the private program that Carol Burnett's daughter went to?

Mr. LELAND. Yes.

Monsignor O'BRIEN. It is an excellent program.

We will be very happy to have you back.

Mr. LELAND. Thank you.

Mr. WAXMAN. Heroin is the primary drug of abuse most often cited by patients admitted to federally supported treatment programs. The second most frequently cited primary drug of abuse is marihuana.

What problems do marihuana users have that would require drug abuse treatment?

Monsignor O'BRIEN, Just to outline for you. There are four general drug families, the opiates—heroin, morphine, synthetic opiates, methadone—the amphetamines that we spoke of a little bit earlier, the barbiturates, the downers, and finally the hallucinogens.

We forget quite often that marihuana is cannibis, and comes from the hallucinogenic family. It is an hallucinogenic and let us not forget that. Hallucinogens create problems.

There was a vast blitz for the last 5 or 6 years, not because the blacks in Harlem or Bedford Stuyvesant, 62 percent of the kids were using some substances like marihuana, but because the important people's children were now using marihuana and were being busted for it.

So we had to change the law. We had to mitigate. Now the scientists are coming up saying, "I think that we made a mistake. We had the highest leaders of our Government keynoting at the NORMAL convention in Washington, who were the White House and NIDA chiefs, who were campaigning for the legalization of that substance.

To get to your basic question, we cannot get caught up in that substance question. If you have an infant in an adult's body, something is going to fill that void. If that person is emotionally adult in an adult's body, he can smoke a reefer, and he is not going to stay with it. It will not have any impact on him at all, and he is not going to be addicted to it, or habituated.

So the problem is that we are not so much a chemically induced or sponsored society, we are, because of a number of reasons, a society of infants. We are producing them in great numbers. Emotionally infants, when you are faced with the threat of adulthood—when you are faced with a threat, if you analyze it, there are only four ways you can respond.

You walk down a dark street at night, like Andy Stein did in Central Park, when you are confronted with a threat, you just analyze that. You can deal with it in terms of anger, and destroy the threat, and we call that violence. You can deal second through the emotion of fear and run away from the threat, and we call that flight. You can do like the turtle, putting its head under the shell, encapsulation withdrawal through substance abuse, and that is the easiest way to deal with it, and most people take that route.

It is interesting that the rape squads are teaching the women in New York to be very calm, to look the person in the eye, and to just talk calmly with the person. It is very difficult.

You have to deal with the threat, analyze the threat, and grow up.

Basically, it is the person that we are concerned with, and not the substance of marihuana. If the young person is an emotional baby and uses marihuana, he is going to have problems, or she is going to have problems.

Mr. WAXMAN. Is that the same problem with alcohol?

Monsignor O'BRIEN. Yes, sir.

Mr. WAXMAN. Congressman Green?

Congressman GREEN. Dr. Trigg, I know that you have many, many successes, such as the Pincer case, and many others. I don't want anything that I say from this point on to question that, or the value of your program to our community.

I think that it is also clear, from an ongoing level of complaints that I get about people hanging around the methadone centers in my congressional district, that there are at least some people who are in the program, and are not successes. They go to the program in the morning, and they go out on the street, and then they act like any addict on the street, and are perceived as dangerous by the people in the neighborhood.

I was wondering, do you have some screening mechanism, at some point, to identify people who are not benefiting from the program, and who, in essence, are simply being drawn into what is another drug scene by their being in the methadone program, or going to the methadone clinic every day?

Dr. TRIGG. Certainly there are questions. This business of loitering; yes, we do have a problem with it. It is much more complicated than I would have thought, if I were not associated very closely with a program.

For example, what is called is loitering, and whatever it is, I am not sure that anybody can define it, is common in East Harlem,

having nothing to do with the methadone maintenance/treatment program. It is a way of life. Loitering is very common in Bedford Stuyvesant and in Brooklyn, having nothing to do with the location of any clinic.

Loitering is not as common, let us say, in the east 60's in New York City, a very fashionable area. There, it is not fashionable to loiter.

We have a very strict policy about loitering. We have loitering patrols that go out regularly. It is in the job description of all staff members. The loitering patrols take down the names of patients. The first time that a patient is seen loitering, he is given a verbal warning. The second time, he is given a written warning. The third time, he is discharged from treatment, which is unfortunate.

In working with the community, I have to show them that I am interested in their community. But I think what the community does not realize is that by literally forcing me to discharge that patient, he not only resumes loitering, but I have no control over him any more.

We have a very close relationship with the police precinct. We do have a memorandum of understanding with community planning boards Nos. 3 and 6. We meet every 3 months. We get the names of our patients from the 9th and 13th precincts, from the police blotter because they may not always tell us that they have been arrested. If we find their name on there, they are in trouble. We put them on probation.

We go round to the local merchants and give them names and phone numbers of staff members that they can call, including Terry out in Staten Island, if they suspect that one of our patients is hanging out in their store or in the neighborhood.

Still this has not satisfied the community, but we have convinced them that we are serious, and that we are concerned about what goes on in the community.

Mr. GREEN. When people initially come in, Monsignor O'Brien indicated that there are certain kinds of people that in the initial screening his staff will decide are not suitable for the Daytop program, but would be suitable for your program. Do you have a similar sort of initial screening?

Dr. TRIGG. Yes.

Mr. GREEN. So there is no self-screening.

Dr. TRIGG. No. We have for years routinely at intake, have asked the patients applying for methadone maintenance if they know about other treatment programs. If they say that they do, we might even sound them out a little bit more, "Tell me about what you know, so that we may eradicate any misgivings that you might have."

If they say that they don't know anything, we can get a representative from Daytop to come down there and talk to patients. We can send patients up here. Even though I was not at work yesterday, I got a phone call at my hotel, and I referred a patient to the executive director of Daytop, because he did not sound like he was amenable to my program.

So there is certainly an easy interplay between, not just Daytop and Beth Israel Medical Center, but other drug-free programs also, but I would say more especially Daytop.

Mr. GREEN. Thank you.

Mr. WAXMAN. Let me thank both of you for your testimony. It has been most helpful.

Monsignor O'BRIEN. Thank you.

Dr. TRIGG. Thank you.

Mr. WAXMAN. I will now call Ms. Betsy Todd, a health educator in New York.

Ms. Todd, we are happy to have you here. Your specialty, as we understand it, is the problems of the aged. We have your prepared statement, and that will be made part of the record. Rather than read it to us, why don't you briefly summarize and highlight some of the points that you would like to bring out to our attention.

STATEMENT OF BETSY TODD, R.N., NEW YORK HEALTH EDUCATOR

Ms. TODD. Thank you.

I am glad to be here. I appreciate your giving some consideration today to the problems that older people have with drugs.

I am a registered nurse. I have been working with senior citizens in particular for the last 5 years, first in Chicago and now in New York, conducting drug education programs for senior citizens.

In the few minutes that I have to summarize, I would like to talk a little bit about what I see as a problem, and give a few suggestions about what I think might be your concerns as representatives of government.

The problems that older people have with drugs are problems of regular drug use, as opposed to drug abuse, and that is the first thing that I want to clarify. There is not a special drug problem among the elderly because older people are drug abusers, or doing awful things with their drugs. The problem has more to do with the fact that older people are at a greater risk in taking medicine.

They tend to take more medicine, and that is for physical reasons—more heart disease, diabetes, arthritis, and so on in older age groups. There are certain physiological changes of aging that result in a slowdown in the way the body handles drugs, and that can result in more adverse effects and toxic reactions.

Older people also tend to have less secure ties with the health care system. Maybe their doctor of 30 years has died, or moved away. Maybe they can no longer afford a private doctor, and go to a clinic where different doctors see them every visit. They do not have good, constant monitoring of their drug intake.

My concern is that older people are a high risk population. They have the same problems with medication that any other consumers do. There are always benefits and risks, but older people are at a greater risk.

They don't misuse medication any more than other age groups. When they do unintentionally misuse medication, while a 30-year-old body may put up with that, a 60-, 70-, or 80-year-old body may not.

The main problem among older people is not psychotropic drug use. I would like to stress that here, since that has been the main topic today. Yes; older people have trouble with valium, librium, sedatives and other tranquilizers, just as other people do. But it is not the biggest part, or even the main part of the drug problem

that older people have. They are having problems with their heart medicine, high blood pressure medicine, diabetes medicine, and so on.

The thing that I should emphasize here is that in an older person, the first sign of an adverse reaction to a drug is usually a change in behavior, a change in mental status. What people are often calling senility, or signs of old age, can be a bad reaction to heart medicine, or to high blood pressure medicine, diabetes medicine that is too strong for them, and so on.

My concern is that these kinds of problems can go unnoticed. People can say, "Well, it is because he is old. That is just the kind of change that we have to expect."

I do have some concerns, which is one of the reasons that I am here today, about the involvement of regular drug abuse programs in drug education for senior citizens.

The typical drug abuse program, whether that is outpatient drug free, or TC, methadone maintenance, or whatever, in most cases is not equipped to deal with the problems that older people have with drugs. Their staff are not familiar with nonpsychotropic drugs, or with the problems that older people have in general, or with their health problems in particular.

There also tends to be an attitude in most drug programs of, "It is wrong to do dope." That is very appropriate, if you are trying to get a person off certain street drugs, or modify a young person's marijuana use, but not appropriate when it comes to older people.

I bring up these concerns because I have seen it happen here in New York City already; very well intentioned people, who really want to help older people, tend to come at them from this angle. "It is wrong to take dope. It is wrong to take medicine. I am going to get you off drugs. If you love yourself, if you fly a kite, if you come to our encounter group, you will not need drugs." Obviously, this is not appropriate with older people.

Certainly, there is a certain amount of over usage of drugs among older age groups as with other age groups, over-the-counter drugs, certain sedatives and tranquilizers, and there is an amount of modifying to be done with that kind of medication. But the main problem really needs to be looked at more from a general health standpoint. I think that I have outlined that a little bit more completely in the testimony.

[Testimony resumes on p. 83.]

[Ms. Todd's prepared statement follows:]

STATEMENT OF BETSY TODD, RN, NEW YORK HEALTH EDUCATOR

I would like to thank the members of the subcommittee for your interest in drug issues, and for setting aside a few minutes today to discuss the problems that older people have with drugs.

My name is Betsy Todd. I am a registered nurse, and have lived and worked in New York City during the past two years. Through the Department for the Aging, Catholic Charities, the Jewish Association for Services for the Aged, and Presbyterian Senior Services, I conduct health and drug education programs for senior citizen groups throughout the metropolitan area. My part time clinical work is at Roosevelt Hospital here in Manhattan, and I also conduct continuing education programs on drugs and the elderly for nurses and other health professionals in several states. My associate, Ronald J. Gaetano, RPh and I jointly cochair the National Task Force on Drugs and the Elderly.

I would like to take this opportunity to share with you my observations and concerns about drugs and older people, based on my experience with over 15,000 senior citizens during the past five years. In the next several minutes, I will

define the problem
briefly describe our approach to it; and
discuss government involvement in this area.

The Problem

The problems that older people have with drugs are most often the result of regular use and unintentional misuse, rather than drug abuse. Four factors contribute to these problems:

1) Most chronic health conditions occur later in life, and many of these involve drug treatment. Because of this, people over 65 make up 10% of the country's population, but take 25% of all prescription medications. Their use of over the counter drugs, "social" drugs (caffeine, nicotine, alcohol), and home remedies at least parallels that of the rest of the population. Studies have shown that the more drugs a person takes, the greater the risk of drug interactions and adverse reactions.

2) The physiological changes of aging result in a general slowdown of the way the body handles drugs. Consequently, a person over sixty is two to three times more likely than a younger person to experience an adverse drug reaction, and there are proportionately more drug-induced illnesses leading to hospitalization among people over sixty. (Exact figures on non-psychotropic drug-induced hospitalizations are difficult to come by, as these admissions are usually described in other ways.)

3) An older person has a decreased reserve capacity for responding to stress--the stress of an illness or move to a new home, as well as the stress of medication. Most drugs that older people take are prescribed (or self-prescribed) for a particular beneficial effect, but a drug is inevitably a stress--an additional chemical for the body to handle.

4) The problems of cost, accessibility, and quality that most people experience in the health care system are compounded for the elderly. The poor prescribing habits of some doctors, lack of accurate health and drug information offered to consumers (especially elderly consumers, who are often thought of as stupid), and inconsistent health monitoring contribute to the problems that older people have with drugs.

In order to be complete, it is important to clarify what is <u>not</u> the

problem here. The main problem is not intentional drug abuse, or "an increased appetite for drugs," as one NIDA official recently put it. Older people are not drug "misusers" or "abusers" any more than the rest of the population. In fact, today's senior citizens probably have a greater respect for drugs than any other age group.

The main problem is not loneliness, depression, and withdrawal. Although these are problems of many seniors, the majority are not "turning to" drugs because of emotional problems. Most of the increased drug use of later life has a physiological basis, not a psychosocial one.

Psychotropic drugs are not the only problem, or even the main problem, for seniors. Recent testimony before various Congressional committees has tended to overemphasize their significance. Drug program people, in particular, are attuned to the use of psychotropic drugs, and when asked about drugs and the elderly, they focus on tranquilizers and sedatives because these are drugs with which they are familiar. DAWN (Drug Abuse Warning Network) data is of little use in describing the medication-taking behavior of the elderly, because it does not include most of the drugs that seniors take. Using DAWN data to project senior citizen drug problems is like going to a kindergarten class to learn how human beings communicate in writing. Crayons are useful, but only represent a small part of the total picture.

Chien and his associates at the Albany Medical College, in their recent study of "Substance Use and Abuse among the Community Elderly," interviewed 242 people over sixty and uncovered the following facts about their drug use:

67% used analgesic drugs (pain relievers)
34% used cardiovasuclar drugs
31% used laxatives
29% used vitamins

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26% used antacids
22% used antianxiety drugs
17% used diuretics (water pills)
14% used cough and cold medicines
12% used hypnotics (sleeping pills)
4% used major tranquilizers
3% used antidrpressant drugs

Obviously, examples of psychotropic misuse and abuse are good for dramatic effect, but not very representative. In fact, one of the main reasons for my concern about drug problems among the elderly is that the resulting morbidity can be so insidious. What is described as "old age" or "senility" is often the (reversible) result of acute or chronic drug reactions.

While alcoholism among the elderly is finally being recognized, it's important to note that people can have serious problems with alcohol without being alcoholics. Alcohol interacts adversely with many prescription and over the counter medicines--not only sedatives and tranquilizers, but many other pills as well. Alcohol in any form can cause these problems--whether it is in wine, beer, or whiskey; or Geritol, Nytol, and cough syrups.

An Approach to the Problem

Faced with drug therapy to manage, most people, including senior citizens, will handle the situation as well as they can within the limits of their knowledge and experience. This often means following the advice of friends and relatives, or making decisions based on often-misleading information presented in drug ads and the general news media. It has been my aim during the last five years to give seniors the "tools" with which to make better informed decisions about their health care in general, and their medication use in particular.

A well designed program of health and drug education for senior citizens

should:

1) Encourage the appropriate use of medications by increasing the consumer's understanding of the therapeutic effects and potential adverse reactions of various drugs.

2) Provide a realistic idea of the limitations and uncertainties of drug therapy, and the role of nutrition and exercise in health maintenance.

3) Share information that will help the consumer to better evaluate sources of drug information (drug ads, newspaper articles, friends' advice, etc.)

4) Increase the older person's interest and confidence in participating in his or her own health care.

It is not the purpose of these hearings to teach members of the subcommittee how to design a drug education program for senior citizens, and time limitations preclude any detailed discussion of the subject. I will be happy to meet or correspond with you or your staff people at any time to share more information on this subject. It is sufficient, at this point, to emphasize that seniors respond positively to this kind of education, and that the effectiveness of these programs has been validated.

Government Involvement

I would like to offer a few specific suggestions to the committee about how, from a governmental standpoint, the problem of drugs and the elderly can be approached.

"We need to redefine what constitutes a "drug problem." The benefits and risks of drugs are markedly different for the elderly than for the usual target populations of drug education programs. The problems that older people experience with drugs may not be as dramatic as street drug overdoses, but the morbidity is significant. We need to educate health professionals as well as

the general public about the quality of life in old age, and about "normal" versus "preventable" health problems.

"Federal agencies need to make a more concerted effort to find out what is already available before beginning new programs. The "reinvention of the wheel" is a currently prevalent and costly practice. My experiences with the National Institute on Drug Abuse and the Administration on Aging indicate to me that these agencies regard privately funded drug education efforts as a) competition, or b) insignificant projects that lack the "validity" of governmental efforts. Both attitudes are counterproductive to cost-effective programming. One way to begin to control federal health spending is to insist that federal agencies take a close look at the many senior citizen drug education programs available around the country, and then offer detailed documentation of the need for additional government spending in this area.

This kind of "program search" should be the responsibility of a person on staff at the agency, rather than a "contracted out" effort, as is usually the case at this time. Contractors have a vested interest in minimizing the extent of other programs and thereby "documenting" the need for new government spending (via a grant or contract to their own firm, of course...). It is interesting, if disconcerting, to watch the development of "instant experts" at Washington contracting firms, whose primary claim to expertise in the area of drugs and the elderly is that they were the first to realize that funding was available.

"No money should be allocated for "model" or "umbrella" programs. Successful rural, suburban, and urban models of drug education for the elderly are well-established. In general (at any rate), federal agencies are several steps removed from the client being served, and it should not be their job to develop

model programs. NIDA's Elder Ed package is a good recent example of an expensive model that was not needed. The contract was funded on a sole source basis; implemented in a city with a large, established drug education program for the elderly (!); and cost five to ten times the amount of privately funded programs already in existence.

"Money should be channeled into community-based efforts. This money should be in the form of "seed money" or matching grants only, to encourage programs to be budget-conscious and financially resourceful. Prospective grantees or contractors should show evidence of community support, and outline a plan to continue their program without federal assistance. This is not impossible. Most of the programs I have worked with around the country began as "borrowed" programs--the result of shared staff time from various agencies, volunteer efforts, and creative funding ideas. Programs will not be cost effective until they are forced to be, and if high priced programs continue to be the norm, money will continue to be wasted.

"Most drug programs are not prepared to conduct drug education for the elderly. There are two reasons for this: first, most drug counselors and administrators have little or no knowledge of legal, non-psychotropic drugs. Second, the attitude fostered in most drug programs is "it's wrong to do dope," and this is not a realistic approach for senior citizens. The drug education efforts of many drug programs consists of: "Many people died last year from Valium! Darvon is addictive! Cortisone is dangerous! Pharmacists are ripping you off!" It is anxiety-provoking and unfair to call this sensationalism "consumer drug education."

In spite of their track record, many drug program administrators will maintain that they are best suited to begin drug education for the elderly (espec-

ially now that more funding is available). Phoenix House, through the use of a Vocational Rehabilitation grant from the Department of Substance Abuse Services, has gathered a group of ex-addicts to teach senior citizens about drugs. The staff states that they have no money to train them. (It's difficult to understand how this qualifies as vocational rehabilitation.) Some have attended my sessions with senior citizen groups, and have made incorrect statements about specific drugs and their effects. The attitude of "don't do dope," and emphasis on "alternatives" to drugs, is evident. The participants are enthusiastic and caring, and anxious to work with seniors; but without training, their "drug education" is no more than the advice of a well-meaning but misinformed friend.

*Drug education programs for the elderly should be developed in coordination with the existing aging network. Any effort that does not tie in with local area agencies on aging and other local health agencies of concern to senior citizens should not be funded. It is inefficient and expensive to create a new network. This seems to be what New York City drug programs are trying to do; none of the programs that have expressed an interest in the elderly have contacted the Department for the Aging. Perhaps they are so unfamiliar with senior citizen programming that they are unaware of the Department's existence. But in working with the elderly, it's imperative to work with the established system--clincis, hospitals, nursing homes, social service agencies, pharmacies, drug companies, etc. Despite the incredible problems of the health care system--and that is not the topic before us today--this is the system that older people use, and that fact has to be respected.

In summary, older people are high risk drug consumers. They want and need more information about their drugs, and should have access to well-planned educational programs. National efforts in the area of consumer drug education do not have to be expensive, and will be best accomplished through the cooperative efforts of public and private agencies.

Mr. WAXMAN. We appreciate that.

Ms. Todd, you are saying that older persons have problems relating to Daytop Village, or other traditional drug-free programs?

Ms. TODD. Yes.

In working with drug programs around the country, which are interested in starting this kind of thing, one thing that we have talked about is that it is sometimes very helpful, depending on your image in the community, to call the program by a different name. It does make a difference on how you are going to attract your clientele. Although certainly in working with seniors, the network is there. In working through the Office on Aging, and making the programs known in that way, it is easy to reach the people.

Mr. WAXMAN. With respect to programs that place some emphasis on seniors drug problems, might they well be run out of the mental health settings as opposed to drug programs?

Ms. TODD. You mean, might drug education for the elderly come out of a mental health setting?

Mr. WAXMAN. Yes.

Ms. TODD. Certainly, there are a lot of programs that could focus on this problem, whether it is a hospital doing community outreach, or whether it is a public health agency, a social service agency, a drug program, or a mental health program, as long as the staff have been trained to do it.

I am not suggesting that a $3 million appropriation is necessary in order to start this up. The talent is there in the communities, if the people work together and coordinate on this sort of thing.

Mr. WAXMAN. I don't know whether you have an answer for this, but do you know from your experience whether NIDA has been sensitive to the problems of the elderly?

Ms. TODD. They have been sensitive to the fact that more prevention money has been available in the last few years.

NIDA for a while appointed a woman to be a coordinator for the kinds of problems that older people have, and they have funded several "drugs and the elderly" programs, whether they are drug education, some treatment monitoring, and so on, which have not had a good history, or a successful history.

I would refer you to the HEW Inspector General's recent review of the three programs, in particular, out of NIDA which had to do with drugs and the elderly.

NIDA's problem tends to be, in my opinion, that they are not aware of the main problem of the elderly, which is what I have been talking about. They have tended to focus more on psychotropic drugs. They are not aware of the need for training. They figure that anybody who knows about drugs can go tell senior citizens about drugs; but you have to know about specific medications.

NIDA recently spent about a quarter of a million dollars to develop what they felt was a model program of drug education for the elderly, which duplicated what has already been done by private efforts around the country for the last 5 to 10 years for about one-fifth the cost.

This particular program, "Elder Ed," has been pushed in New York State and in New York City recently. My concern, as was the HEW Inspector General's, is that the materials that were produced

are not complete enough, and can lead to misunderstandings and misconceptions among senior citizens, which can be doing more harm than drug education. They can actually make the problem worse instead of better.

Mr. MURPHY. Ms. Todd, Betty Connelly, an assemblywoman from Staten Island, and also chairman of the New York State Assembly's Mental Health Committee, charged that the nursing home patients are heavily into the use of drugs, not on a voluntary basis, but almost on a prescription basis, because it calms them down, "She is a nice old lady, and she will not know what is going on." Actually, in that institutional type setting there is drug abuse.

Ms. TODD. We need to separate into two areas the kinds of problems that older people have with drugs. There is a problem in some nursing homes, but the roots of the problem are very different from the problems that the older persons in the community have.

More than 95 percent of people over the age of 65 are in the community, and mostly managing their own medication regimens, or wife is doing it for husband, or son is doing it for mother, or whatever. Basically, however, it is the consumer making the decision about medications.

In a nursing home or other institution, where we have just under 5 percent of people over 65 at any one time, the drug decisions are made by the staff. Certainly there is a problem with over sedation and over tranquility in many nursing homes, but the problems do not have to do so much with educating the consumer, as educating the health professional about how much of this drug is necessary, and what other interventions are necessary with the elderly.

It is a problem that affects a smaller number of the population which is one thing that makes it different, but does not deny the problem. It is also a problem that has its roots more directly in what the health professional is doing.

In working with senior citizens in the community, I am trying to reach those who are making health care decisions for themselves, which is not to negate the need for professional education.

I have come here today from a program at Pace University, where we have over 100 nurses there today who are interested in learning about the problem that older people have with drugs. So professional education is an important part, especially where the professional has such control over the drugs that are being given.

Mr. MURPHY. Your prepared statement indicated that the program can certainly be done at the local level.

Ms. TODD. Absolutely.

Mr. MURPHY. You don't think that the ivory tower can run it.

Ms. TODD. I would tend to have that opinion about most health programs. It is very difficult to be several steps removed from the person in the street, from the senior citizen in the community, such as a NIDA administrator—it is very difficult in the ivory tower to know what program will work best in different areas.

I have seen urban programs, suburban and rural programs around the country that are meeting the specific needs of their areas.

I would rather see the Federal Government more involved in public education, encouraging community-based programs, rather

than always trying to develop models which inevitably end up not being applicable to anyone.

We have seen that problem in drug abuse programs for years. The regulations don't fit, so the programs have to lie to continue to get their funding.

Mr. WAXMAN. Mr. Green?

Mr. GREEN. Ms. Todd is a constituent who has already been briefing me on her concerns as to the direction of the Federal programs in addressing the problems of the elderly in connection with drug use. I just want to express my appreciation to you, Mr. Chairman, for scheduling her today.

Mr. WAXMAN. Thank you very much.

I just want to mention that it fascinates me that Americans over 65 represent only 10 percent of the population, but consume 25 percent of all prescription medicine.

Ms. TODD. Right.

Mr. WAXMAN. Prescription drug misuse can occur at all ages, but particularly in this age group.

Thank you very much.

Ms. TODD. I will leave with you also, if you are interested in further information on specific drug education programing for seniors, a short article from hospitals magazine.

Thank you for your time.

Mr. WAXMAN. We will place the article in the record.

[The article mentioned follows:]

EDUCATING THE ELDERLY IN SAFE MEDICATION USE

by Janet Plant

Pioneering program takes public health education approach to drug misuse among the elderly

Behind the common stereotype of the elderly, which is based on the much studied 5 percent of people over 65 who reside in nursing homes and whose medication regimens are supervised daily, looms the other 95 percent, who live in varying degrees of self-sufficiency in the community and who generally are responsible for their own medications. Many in this larger group have one or more chronic illnesses that require several medications. Although they are reasonably self-sufficient, the chronically ill elderly are nevertheless very vulnerable to medication misuse. They often double a dosage if they have forgotten to take a drug earlier or if they are feeling very ill, never realizing that severe toxicity can result. Failing memories and hearing make it difficult for them to remember a physician's dosage instructions, and failing eyesight makes it difficult for them to read the fine print on over-the-counter drugs or the uninformative "To be taken as directed" on some prescription drug labels.

In an effort to correct this situation for the elderly members of its community, Augustana Hospital and Health Care Center, Chicago, launched a Seniors' Health Program in 1978. The program's first year was funded by an Illinois Public Health Trust grant of $28,000 that was earmarked specifically for combatting drug use problems and by

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(Left) Health education talks on medication safety, analgesics and antibiotics, and such chronic illnesses as diabetes and arthritis are delivered by Seniors' Health Program staff in an upbeat, expressive style. Betsy Epstein, R.N., explains high blood pressure and safe drug use by hypertensives, as part of a series of Seniors' Health Program presentations at a Chicago bank. (Right) Jerry Parker, a geriatric social worker who heads the program at Augustana Hospital and Health Care Center, fields a question after a health education talk at a senior citizen apartment complex.

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a $6,000 grant from the area agency on aging. Under the direction of two half-time geriatric social workers and a full-time registered nurse, the program focuses on meeting the drug use education needs of the elderly in the Chicago area, and at the same time, attempts to help further define and determine the extent of the problem nationwide. To date, this undertaking has proved to be an ambitious, many-faceted program consisting of group health education, local and out-of-state conferences for health care personnel, health fairs, some individual counseling, and research.

The hospital's interest in such a program is natural, given the fact that the 325-bed Lutheran-affiliated institution has one of the highest Medicare admission rates in Chicago. As staff members of the Seniors' Health Program explain the rationale for their effort, "The situation [of drug misuse] is not as dramatic as that involving the illicit use of drugs, but our observations indicate it is a much greater public health problem."[1]

The Augustana program's primary emphasis on health education seems a logical one for many reasons. Health education is designed to meet the consumer's need for health care information in simple, direct terms. The program also seeks to focus on the consumer, because "The primary [effort] should be on reaching the client himself, rather than a lot of effort on significant others [family, health professionals]. . . . An individual cares more about his own life than others [do] and should be the coordinator."[2] Moreover, program staff believed that health education would be the most effective approach, given the financial resources available in the first year of operation. In addition, Jerry Parker, a geriatric social worker who directs the program, had assessed community resources for the elderly and discovered that nothing in the way of health education had yet been developed by the Mayor's Office on Senior Citizens or by the public health department.

The staff of the Seniors' Health Program has developed health education talks on medication safety, laxatives and bowel preparations, analgesics and antibiotics, vitamins, and sedatives, and they have incorporated medication information into talks on diabetes, high blood pressure, arthritis, and other chronic illnesses of the elderly. The talks, most of which are given by Betsy Epstein, a registered nurse with community health nursing experience, invariably provide information to combat the most common and potentially dangerous self-medication habits. As determined by studies and the observations of Augustana staff members, these habits include:

- A lack of knowledge of the name and reason for a particular drug.
- A lack of knowledge of how a particular drug must be taken to be effective (with or without food, chewed or swallowed whole, and so forth).
- A lack of knowledge of what a side effect is. Because the elderly are more prone to side effects and tend to stop taking critical drugs that may produce unpleasant side effects, the talks emphasize that the elderly should be alert for common side effects and, above all, that they should discuss such reactions with a physician.
- Stretching medicine to last longer or taking more than what is prescribed in the belief that two pills are better than one. Chronically ill patients often are unaware that some medication doses are carefully adjusted because of other medications they are taking and that by increasing or decreasing the intake of one, they are inviting trouble.
- Borrowing and lending medicines.
- Saving old medicines and tending to self-treat with them.
- Taking medicines irregularly because of forgetfulness, illness, and other conditions.
- Overusing over-the-counter drugs because, in their search for better health, the elderly seem especially susceptible to nonprescription drug advertising.

Word spreads

Program staff members are invited to give their presentations in places where the elderly congregate—nutrition sites, libraries, senior citizen apartment complexes, and churches and synagogues. Parker and Epstein admit that they have been successful in reaching a large audience with their talks, because they have been able to operate within a fairly well-established senior citizen service network in Chicago. There has been little need to publicize what the program offers; word simply has spread throughout the network and has generated enough invitations to keep the staff busy. Even before the program officially started, Parker made contact with about 60 community social agencies and asked for representatives to serve on an advisory board that would provide community input. A core group of 15 to 20 individuals continues to meet every six weeks as the advisory board.

The health education presentations consist of an explanation in graphic, understandable terms; a general question period; and an individual question period for those who do not feel comfortable asking questions before a group. Few audiovisual aids are used, because the facilities in which the talks are given vary and because staff members firmly believe that the personal approach carries the most weight with the elderly, who may feel put upon in general and who believe they are given short shrift by health care professionals in particular.

A few handouts are distributed during the talks. Organizations such as the Chicago Heart Association provide some, while the staff develops and adapts others from existing materials, usually by condensing and simplifying the information and printing the handouts in large letters for easy readability. Specially developed handouts include a patient medication profile that the

elderly can maintain themselves or with the assistance of a pharmacist and a checklist of general medication do's and don'ts.

Evaluation of the talks' effectiveness has come about in rather indirect ways. Many senior citizen groups who extended invitations for a first talk ask for more presentations and eventually end up asking for the entire series. Favorable reviews have spread by word-of-mouth so that there is no need to publicize the program in local newspapers, on posters, and the like. For instance, 300 units of health education were given in the first three months of the program's operation and 4,200 units in the next six months (one unit is defined as one elderly participant receiving one health education topic). Questionnaires distributed early in the program told the staff that it was on target with regard to topics and clarity of presentation. Pretests and posttests have been used in a few settings; however, staff members see them as threatening to the participants and to the rapport that they seek to establish with the elderly.

Now in its second year of operation and with a budget of about $42,000, mainly from charitable foundations, the program has extended its health education activities to include four health fairs and formal educational courses. The fairs are being held in an effort to reach older adults who are not "joiners" and who therefore would not have heard the health education talks presented before organized senior citizen groups. Posters displayed in hotels, pharmacies, and grocery stores are the main vehicle for announcing the fairs. Eighteen social service agencies set up booths at the first fair, held last October; two pharmacy students counseled the elderly, who had been urged to bring along the medications that they wanted more information on; and blood pressure and hearing tests also were offered free of charge.

The formal 10-session courses will be offered for a small registration fee through Mandelein College, a private institution in Chicago, and through the Open University, an adult education project for people 55 and older, sponsored by the Council for Jewish Elderly and the Jewish Community Centers of Chicago. The courses will consist of essentially the same health education presentations that the program staff gives informally every day. However, because the course will be more of an organized educational offering, it will give the Seniors' Health Program staff a chance, through assignments and the like, to cover more material in greater depth and to more accurately gauge educational impact.

Health education presentations are attended mainly by lower and middle-income whites, Epstein says, partly because there has been a problem reaching and heating senior citizen groups among minorities. Once, when she presented a workshop in a Latino community, she had to use an interpreter and found the communication process difficult.[5] Since then, however, she has given successful presentations to Japanese, Greek, and Italian groups with the help of a translator and handouts written in the group's language.

An effort to reach older adults before they left the work environment, by delivering a health education talk as part of a company's preretirement planning program, did not prove as successful as expected. Audience interest level, as shown by the questions asked, was not as high as usual, according to Epstein.

Individual counseling, though not a regularly planned activity of the Seniors' Health Program, is a natural result of the group presentations. For instance, during the individual question periods following the health education talks, questions are posed by the elderly, sometimes on proper medication procedures and at other times on a multitude of health-related problems. Typically, in response to a question, a member of the staff will do on-the-spot teaching and counseling and/or refer the elderly person to a physician or social agency or make a home visit. In this capacity, staff members see themselves as gap-filling—that is, filling actual gaps in the health care system or gaps in the older people's knowledge of the system.

Consciousness-raising

If the primary aim of the Seniors' Health Program to date has been to instill in the elderly a new understanding, respect, and responsibility for the drugs they take, running a close second is the aim to instill in health care personnel a better understanding and respect for the special medication problems of the elderly. This aim is being implemented through conferences for professionals and through research.

The first drug awareness conference, held in Chicago in April 1976, drew mainly social workers, people who work in senior citizen apartment complexes, and registered nurses in the Chicago area. The intent of that one-day workshop, and of the out-of-state conferences held since, was to help health care personnel encourage the elderly to become active partners in their own drug therapy. Health care personnel tend to resist the concept, Epstein says, because they conceive of the elderly as being the seriously ill, incapacitated, somewhat confused beings they encounter so often in the hospital setting and because they believe the elderly cannot, as a rule, care for themselves, let alone become more responsible participants in their own health care.

In fact, in pretests conducted at professional conferences, most health care personnel indicated that 50 percent of persons over 65 reside in nursing homes. Epstein firmly believes that health professionals tell the elderly short, when they equate persons over 65 with nursing home residents and equate the gradual memory loss that is typical of the aging process and the temporary confusion caused by ill-

ness with ease.

The elderly who suffer failing eyesight, diminished hearing, and memory loss can be successfully educated, Epstein maintains, if these differences are compensated for rather than viewed as insurmountable hurdles. For instance, written materials can be printed in large, readable type, and memory aids, such as a large calendar, can be used to help the elderly implement a medication schedule. As one family nurse practitioner has observed: "Numerous gimmicks have been devised by nurses working with the elderly in the community to help to train them in spite of such problems as diminishing eyesight, mild states of confusion, forgetfulness, and anxiety. I have found that almost any person who is self-sufficient enough to live in a hotel room or in a small home is able also to comply with a drug regimen."[3]

Speakers at the professional conferences, which usually are conducted in cooperation with the Broome County Drug Awareness Center, a sister project in Binghamton, NY, and which draw around 50 to 100 participants, include nurses, pharmacists, social workers, and physicians. The speakers delineate common medication problems among the elderly, identify ways in which the aging process magnifies misuse problems, discuss implications of medication misuse for nursing care, and explore possible solutions to the problem while emphasizing the team approach. Pretests, posttests, and evaluation forms are integral feedback mechanisms built into the conferences.

As time and resources permit, the Seniors' Health Program staff plans to develop drug awareness workshops locally for Lutheran ministers, the administrators and group leaders in senior citizen apartment complexes, and community group leaders—all of whom can serve as vital links between the elderly and the health care system. The workshops would function as the vehicle for a two-way exchange of knowledge and a comparison of resources.

The media have been used from time to time to educate the general public as well as the elderly to the drug misuse problem. Television coverage has included segments on a daytime interview show and an evening news program. In addition, Epstein has written 20 health education articles for a local senior citizen newspaper with a circulation of 30,000. Such one-way communication is not ideal, according to Parker and Epstein, but it is a way of reaching a number of people with health information.

Research on drug misuse

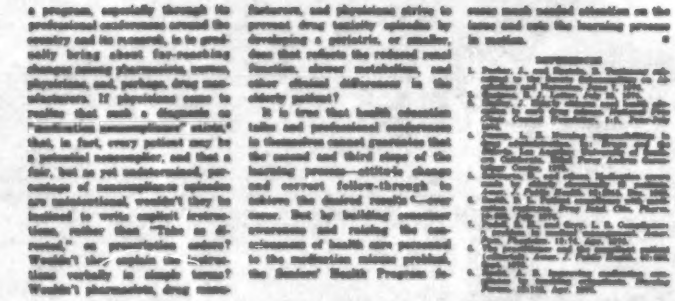
Until the last two years, very little research into the drug misuse problem of the elderly has been conducted since a 1963 study.[4] The Seniors' Health Program therefore acknowledges a responsibility to carry on research, in the interest of formulating new directions for the program itself and of contributing to the growing awareness of the problem nationwide. In an attempt to discover, in part, how much drug use is intentional and how much is unintentional, program staff members have been involved in descriptive research and data collection on a small scale from the program's inception. One study of a sample of 75 elderly Augustana Hospital outpatients will attempt to assess their medication use as well as some of their health needs. In a second study, local pharmacists are being asked to describe the services they offer to the public and to explain why they think the elderly often fail to comply with medication regimens. Data from the latter survey will be shared with area pharmacists in an effort to strengthen this crucial link in the development of informed drug use by the elderly.

Parker and Epstein will have further input into the national effort as appointees to the Task Force on Drugs and the Elderly, which will develop educational sessions on the subject for the 1977 Drug Abuse Conference. Also, in testimony before the Senate Subcommittee on Aging and the Senate Subcommittee on Alcoholism and Narcotics, they described the nature of the drug misuse problem among the elderly and explained how the Seniors' Health Program evolved as one attempt at solving the problem.

Role as catalyst

A pioneering effort such as Augustana Hospital's builds awareness that in turn can motivate individuals—patients as well as health care personnel—to change or to work for change. The program rightfully puts the spotlight on the chronically ill patient as having the ultimate responsibility for complying with his drug therapy, but it recognizes that the patient cannot do so effectively if there is too much information about medication use and misuse of which he is unaware. As one pharmacist has written: ". . . no drug is effective unless it is properly prescribed, dispensed, and accurately administered. This chain of responsibilities demands knowledge on the part of the physician, the pharmacist, and the patient. Unfortunately, we have often forgotten the educational requirements of the patient and have overlooked the significance of his contribution to the drug therapy."[5] The case for consumer/patient education in safe medication use is also acknowledged by others.[6-9]

Educating the elderly consumer/patient is much of what the Seniors' Health Program is about, but that is not the program's only aim. The potential influence of such



Mr. WAXMAN. We will now call two gentlemen to come forward together as a panel, Dr. James J. Turanski, program director, the Door—A Center for Alternatives; and Rabbi Murray I. Friedman, chairman, New York City Council of Substance Abuse Prevention/Intervention programs.

We have both of your statements in hand, and they will be made part of the record. Please summarize those statements and highlight some of the points for discussion.

Dr. Turanski, why don't you start off?

STATEMENTS, OF JAMES J. TURANSKI, M.D., PROGRAM DIRECTOR, THE DOOR—A CENTER OF ALTERNATIVES, ACCOMPANIED BY DONALD L. SHAPIRO, COORDINATOR OF DRUG ABUSE SERVICES; AND RABBI MURRAY I. FRIEDMAN, CHAIRMAN, NEW YORK CITY COUNCIL OF SUBSTANCE ABUSE PREVENTION/INTERVENTION PROGRAMS

Dr. TURANSKI. I am Dr. James Turanski, the program director of the Door—A Center of Alternatives. My colleague is Don Shapiro, who is the coordinator of the drug abuse services at the Door.

The Door is a community-based, comprehensive, multiservice center for adolescents between the ages of 12 and 21, located in lower Manhattan. The Door provides a wide range of services, activities and programs for young people. We have tried to describe that in our written material, so I will not repeat it.

Our approach is to help young people to resolve the problems which they see as important to help them develop the skills that they need for an effective and constructive functioning in society, and to help them to have something meaningful to do to relieve their boredom.

In its 8 years of operation, The Door has been effective in reaching a large number of young people from a wide variety of backgrounds. We see approximately 350 to 400 young people on a daily

basis, and approximately 2,200 different individuals in a month's time.

We appreciate the opportunity to testify before you today, to share some of our ideas as they relate to the issue of drug abuse prevention, and to respond to your request to know more about The Door. Because of our program's focus, much of what we will say will deal with an adolescent age group.

In our written testimony, we stress the importance of looking at drug use as a form of behavior occurring within the context of the adolescent developmental process. Regular use of drugs can result in an avoidance of the often painful and difficult developmental tasks and issues which are part of the adolescent stage.

Compulsive drug use can have dysfunctional effects on an adolescent's life, can induce a tendency toward passivity and inactivity and can greatly retard the resolution of the adolescent's developmental tasks, which are important steps in the development of a mature, creative, and responsible adult.

The use of drugs as a means of avoiding dealing with normal life problems frequently becomes adopted as a pattern of behavior which extends beyond adolescence and into adulthood.

In our written testimony, we have tried to make clear that young people who abuse drugs have a large variety of motivations for using drugs. They have a diversity of needs and potentials. They have many patterns of drug abuse, and they experience different consequences of their drug use.

It is important that the approach to adolescent drug abuse problems be comprehensive, and that prevention, early intervention, treatment and rehabilitation efforts be involved. Programs designed for adolescents should be easily acceptable. Many times adolescents do not see drugs as a problem, and so you will have to address the issues which they see as important, and deal with the drug problems later.

These programs will have to have a wide variety of resources available to deal with both the causes and the effects of drug abuse. In addition, they should be able to help young people acquire the skills that they need for later societal functioning as adults, and they will have to identify meaningful alternatives to drugs.

The Door has attempted to develop such a comprehensive program for adolescents. We have described our program fully in the written materials. I will not describe it more.

I would like now to address the issue of drug abuse prevention.

First of all, we wholeheartedly endorse the idea of placing more effort and more financial resources in drug abuse prevention. It has been a long time in coming. We applaud the new direction.

It seems only reasonable to try to prevent dysfunctional drug taking behavior from occurring, especially when it becomes much more difficult and more costly to eradicate this behavior once it is well established.

Two important target populations for the prevent approaches are the preadolescent and the adolescent age groups because it is during these age periods that drug taking behavior first begins, and is first learned.

By preventing young people from acquiring dysfunctional drug taking behavior, there will be considerable reduction in later suffering, hardship and loss of productivity, which affect both the individual and society.

It is important that emphasis be placed on the development of innovative and effective strategies for drug abuse prevention. These strategies will have to go beyond traditional information and educational approaches.

Prevention efforts must aim at helping individuals to resolve those problems or life circumstances, which frequently foster the use of drugs. We should aim at providing positive alternatives to drug abuse. We must help provide individuals with the understanding, the values and the skills they will need to lead constructive and fulfilled lives without the need to use drugs.

On a more concrete level, this might mean that because there is often an association between drug abuse, school dropout, unemployment, that programs geared toward prevention of drug abuse may help young people who are school dropouts, or unemployed, to get the schooling and to complete the training that they will need in order to really make it in society, so that drug abuse does not have to become an alternative for them.

It is important that sufficient financial resources be allocated to develop efficient and effective preventative programs. The prevention should not be seen as an easy or inexpensive way of resolving the drug problem. The problems, or life situations underlying drug abuse are not easily resolved, and will require a multidisciplinary approach. The time taken for resolution may be long. However, the cost for a prevention effort which is effective is expected to be significantly lower than the long-term costs to the individual and society resulting from drug abuse.

We would like to recommend that future Federal appropriations to the National Institute on Drug Abuse be increased to cover the cost of a new prevention effort, and to ensure its success.

We would also like to recommend that consideration be given to joint funding by various Federal departments, such as the Department of Health, Education, and Welfare, the Department of Labor for prevention programs, focusing on a particular population, such as adolescents. Since an effective prevention strategy will require a multidisciplinary approach, it seems appropriate that a coordinated approach by these departments be tried.

Thank you.

[Testimony resumes on p. 113.]

[Dr. Turanski's prepared statement follows:]

STATEMENT OF JAMES J. TURANSKI, M.D., PROGRAM DIRECTOR,

THE DOOR--A CENTER OF ALTERNATIVES

Overview

I am Dr. James Turanski, the Program Director of The Door - A Center of Alternatives; my colleague is Donald Shapiro, the Coordinator of Drug Abuse Services. The Door is a multiservice center and center of alternatives located in Lower Manhattan and designed specifically for young people between the ages of 12 and 21 years. The Door provides a wide variety of services, programs and activities which will be described later. By offering help in resolving those problems which young people see as important, by helping them develop the skills they need for effective and constructive functioning in society and by providing them with something meaningful to do and relieving their boredom, in its eight years of operation The Door has been effective in reaching and involving in ongoing programs a large and diverse group of inner-city adolescents, many of whom use drugs or are at high risk of using drugs. We see approximately 350 to 400 young people on a daily basis and approximately 2,200 different individuals in a month's time.

We appreciate the opportunity to testify before you today from our experience in regard to the issue of drug abuse prevention and to respond to your request to know more about The Door. Because of our program's focus, much of what we will say will relate to an adolescent population. We would like to explore the significance of drug use within the context of the adolescent developmental process and to discuss some motivations underlying the use of drugs. After describing The Door's drug treatment program, we would then like to discuss a variety of drug abuse prevention strategies which The Door utilizes in responding to the needs of young people who are at risk of abusing drugs.

Drug Use Within Adolescence

In seeking to understand and effectively prevent and treat drug abuse in adolescents, it is important that human service providers look at it as a form of behavior occurring within the context of the adolescent developmental process. Regular use of drugs can result in an avoidance of the often painful and difficult developmental tasks and issues which are part of the adolescent stage. Adolescence is a time of rapid change and resolution of basic developmental issues in regard to identity formation, sexual identity, societal roles, dependence and authority. Compulsive drug use can have dysfunctional effects on an adolescent's life, can induce a tendency toward passivity and inactivity and can greatly retard the resolution of the adolescent developmental tasks which are necessary steps in the development of a mature, creative and responsible adult. The use of drugs as a means of avoiding dealing with normal life problems frequently is adopted as a pattern of behavior that extends beyond adolescence into adulthood.

The adolescent phase of development is a time which is characterized by physical, sexual, intellectual, emotional and social changes, all of which result in considerable anxiety and confusion and which demand readjustment and reintegration of a constantly changing view of the self and others. It is a time of movement away from a dependent relationship with parents or guardians, toward becoming an independent and autonomous human being in relationship to peers and adults. Normally there is a period of depression and insecurity over the loss of the security of childhood and the recognition of the need to meet life independently. Adolescence is also a time of great

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intensification in terms of acquiring the skills necessary to function successfully as an adult. This includes the development of learning tools, working patterns, socialization skills and adult coping mechanisms. Throughout the period of adolescence there is a process of identity diffusion and identity formation which demands an ability to tolerate a constantly changing identity and to remain open to new perceptions of oneself. These changes and new demands produce anxiety, tension, sadness and insecurity in normal adolescents which must be tolerated if the developmental issues are to be resolved. In young people who, because of difficult early childhood experiences, reach adolescence with little security or trust in their own ability to successfully deal with life, these anxieties can become especially overwhelming when appropriate support is not present in the environment.

The temptation is great at this critical time of life to use drugs in an attempt to lessen the constantly present insecurity and uncertainty. When drugs are regularly used during adolescence, whether to relieve the normal anxiety and stress associated with the challenges and demands of this developmental phase of life or as a result of peer pressure, it creates dysfunction and interferes with the young person's perception and experience of reality, and his willingness to confront and deal with the emotional discomfort associated with his new experiences.

Many young people feel unable to go to school or work, to socialize and relate with peers, to cope with family tensions or to deal with unstructured time unless they are "high." In this "high" state the young person often attempts to resolve problems in fantasy rather than through a real interaction with life and in this way avoids coming to terms with his increasing difficulty in coping with normal life tasks and challenges. Through this compulsive use of drugs, the normal drive to develop the specific skills, abilities and emotional stability which are prerequisites for mature adult development are inhibited. This further leads to defensive behavior patterns, passive, inactive and indirect ways of dealing with life and often a continuing and increasing reliance on drugs by the adolescent, to enable him to cope with day-to-day life.

In adolescence it is not the pharmacological properties alone which make a drug harmful to the individual, for even drugs which have a less serious pharmacological effect can have a serious effect on the psychosocial development of the individual. Thus regular compulsive use of any drug becomes a serious problem, potentially affecting the person's future life and future ability to function. For these reasons, it is imperative that appropriate support, early intervention, treatment and alternatives be provided at an early stage for those adolescents for whom drug-taking behavior is likely to become or is becoming a way of coping with normal life problems. This should be done regardless of the drug being used at any particular point in time, for drug choice can be affected by many factors and the "least serious drug" can be easily replaced by drugs which are considered more harmful to the individual or to society. It is more important that drug-taking behavior be recognized early in an individual's life and that more appropriate, constructive and rewarding coping mechanisms be provided. When an individual has been into "heavy" drugs for many years, has already developed a drug-oriented

life-style, has a negative and defeated self-image, and has depleted all possible resources, it is much more difficult and ultimately more costly to society to help this person to become a mature, creative, responsible and productive adult.

Motivations and Consequences of Adolescent Drug Use

In order to better understand adolescent drug use and to develop a comprehensive prevention and treatment approach to this problem, it is important to explore those factors which motivates adolescent drug use and to consider the consequences which drug use has on the lives of young people. Many young people live in an environment where drug abuse is highly prevalent and drugs are easily accessible. Many live with pressing daily problems such as rundown housing, financial insecurity, lack of proper food, oppressive and unbearable family situations, and exposure to exploitation by drug pushers, pimps, hustlers and gangs. Drugs often play or come to play a major role in the lives of these young people, many of whom use drugs in an effort to find relief from the hopelessness and deprivation of city and ghetto life, in an attempt to escape from their problems, frustrations, anxieties or confusion, or in rebellion against parents, schools, traditional institutions and the values and life-styles of a society seen as hypocritical and dehumanizing. Many young people turn to drugs, especially psychedelic drugs, in an attempt to gain insight or to achieve altered or expanded states of consciousness or awareness. Many turn to drugs, especially hard drugs, in order to escape boredom, depression or frustration. Many others are tempted to try drugs as a result of peer group pressure or as a way of "turning on," "getting high" or simply having a good time. Their days are often spent hustling for money or dealing dope in order to obtain drugs for themselves, smoking, popping pills or shooting up in abandoned buildings, and basements, on rooftops, in the parks and on the streets.

It is often within the context of the family that many of the psychological antecedents of drug use and other self-destructive behavior can be found. Certain patterns of family interaction reinforce and perpetuate behavior which is limiting and negative. A troubled young drug abuser frequently takes on the role of scapegoat within the family structure which serves to maintain the stability of the family's way of functioning, no matter how disorganized or destructive it may be.

Many adolescent drug abusers are isolated, alienated, and depressed, and have difficulty expressing themselves interpersonally and functioning in a productive and creative way. As they separate from their families, they look to their peers for support, direction and confirmation of their identity. Instead, they frequently experience competition, lack of support and exploitation. They fall into destructive patterns of relating and often allow themselves to be pressured into drug abuse and self-destructive behavior because of their need for acceptance, belonging and peer approval.

Many young people use drugs to escape from the emptiness of their relationships and their sense of inadequacy and worthlessness. Drugs are often used in an attempt to enhance sexuality, as a "turn-on" or to relax

inhibitions and anxieties. They are used out of a feeling of needing external help to function effectively in sexual relationships or as a means of avoiding responsibility for failure. On the other hand, many drugs actually interfere with sexual desire and functioning, so that drug use itself can precipitate sexual problems where none previously existed.

Young people with emotional disorders are particularly vulnerable to pressures contributing to drug abuse, especially with the widespread use and easy availability of drugs. Anxiety, depression or psychotic reactions lead many of these young people to use drugs such as barbiturates, amphetamines, tranquilizers and antidepressants, often in an attempt at self-medication. Psychedelic drugs are a particular threat to psychologically labile young people and at times provoke severe breakdowns and long-lasting mental disturbances.

Many young people who have been using drugs extensively are physically run down, frequently show serious debilitation and have chronic physical illnesses (e.g., hepatitis, gonorrhea, anemia, tuberculosis and ulcers). Many have demonstrated a serious disregard for and misuse of their bodies, failing to provide adequate sleep or medical care. Many youthful drug abusers show signs of general undernourishment or malnutrition. A drug-centered life-style often means poor choice of food, infrequent and irregular meals, and disregard of basic nutritional requirements.

Many young people are bored, frustrated and frequently alienated from their schools. They find school inadequate and irrelevant to their needs and interests. Many feel confused and apathetic and find little sense of direction or meaning in their educational program. They drop out or are only marginally attending school. They find their opportunities for employment or involvement in any meaningful activity severely limited. Often these youth become involved in drug abuse which further limits their educational opportunities. When on drugs they find it hard to concentrate while in school, have difficulty learning, and fall behind in their studies. They generally drop out and become actively involved in a self-destructive, drug-oriented life-style.

Many young people, especially those from poverty areas, are in need of full-time, part-time or after-school work in order to support themselves or to supplement their family's income. Many youth accept poor paying, unskilled employment such as temporary factory work, messenger or janitorial jobs, because of their own lack of information and experience in seeking employment or training or because of previous histories of drug abuse or criminal offenses. They often lack self-confidence and set limited vocational goals for themselves. The many youth who are unemployed or who are bored and frustrated by dead-end jobs, frequently turn to or return drug involvement and a negative life-style.

Many young people who are using drugs have arrest records, pending criminal or juvenile cases, outstanding bench warrants and other legal problems which are often associated with a drug-centered life-style. The frequently become involved in civil legal difficulties such as debts and landlord/tenant problems. Problems such as these make returning to or leading a "normal" life-style (e.g., getting back to school, getting a job or finding a place to live) very difficult event for a well motivated person.

Whether the initial motivation to try drugs is to have fun, to feel good, to belong, to relieve stress or tension, to tune in, or to tune out, people misuse or abuse drugs when efforts to meet their basic human needs are thwarted or frustrated. When the void remains unfulfilled, or when meaningful alternatives are not available, drugs are perceived as an option or substitute.

Studies show that the incidence of drug abuse within a given group is related to the number of people within that group whose basic human needs are not being met by the group or by the larger community or by society.[1] Individuals have needs which go beyond those necessary for basic survival, food, clothing and shelter.

1. The need to relate to others; to be able to love and be loved; to accept and be accepted; to feel good about oneself.

2. The need for having some control over one's life; having a sense of competency and life skills; being able to cope and provide for one's needs.

3. The need for cultural identity, a sense of one's place in the world; pride in one's racial heritage, for equal opportunities regardless of race or sex or age.

4. The need for spiritual satisfaction, for feeling a part of or being involved in something larger than oneself, for learning about the world in which one lives and the meaning of one's life.

5. The need to actualize one's creative potential, to continue to learn and grow as a human being, as well as the need for constructive ways to fill one's leisure time; to have fun; to experience healthy forms of recreation.

6. The need to feel that one can contribute to society and to the common good, to feel needed; to have relevant education and meaningful employment.

7. The need for factual information to help in decision-making and in clarifying values.

8. The need for social or group support in times of crisis, for services which strengthen a troubled person who is having difficulty in school, in the community or in the family.

The Problem of Adolescent Drug Abuse

The abuse of drugs by adolescents continues to be a major problem faced by many countries of the world. Evidence of increased use of drugs among adolescents and the consequences of this increased use, are of major concern to human service providers in the United States. Drug abuse is seen as promoting dysfunction in many dimensions of the lives of young people and aggravating other problems. It results in suffering, hardship and loss of

productivity which affects both the individual and society. It is related to criminality and is seen as an important factor in deaths or accidents among adolescents. In spite of the increasingly voiced concern over the consequences of adolescent drug abuse, human service professionals have not been particularly successful in preventing the abuse of drugs by adolescents, nor have they been successful in reaching drug abusing adolescents and involving them in therapeutic programs which are capable of rehabilitating them. A major reason for this lack of success is related to the fact that young people often do not see their drug use as a problem. For many youth, drugs are seen as a regular part of their daily lives, which, if anything, are useful in relieving boredom, in alleviating painful life experiences and in dealing with the difficult developmental tasks which are inherent in the adolescent process. Even those young people who experience extensive debilitating effects on their lives are apt to deny the relationship between their drug use and the problems which they experience in their lives. They do not see that this use is a consequence of other problems and that it aggravates existing problems or causes others. When asked directly if they feel that their drug use is a problem or if they want help in reducing the extent of their drug use, the majority of young people say no. The lack of insight into the consequence of drug use on their lives and the lack of motivation to reduce the extent of their drug use, are serious impediments which human service providers must overcome before the drug problem can be resolved.

Even when youthful drug abusers do have insight, and are motivated to reduce their drug use, many fail to receive the help or care they need because they are unaware of the various services available to them, or are uncertain of how to use them. Some young people are unable to afford the needed services because of limited financial resources. Others hesitate or refuse to go to established agencies or institutions out of mistrust, fear, embarrassment, or alientation from what they consider impersonal, inflexible, and dehumanizing services. They frequently encounter staff who are not comfortable with adolescents, do not understand their problems, and cannot communicate with them. Other young people, fearing that their problems will not be kept confidential, especially from their parents, avoid programs where it is known that parental consent is required. Still others fear there will be legal consequences if they disclose their abuse of drugs.

Many of the existing mental health or drug treatment programs do not address the unique needs of the adolescent population. Many treatment programs are not equipped to deal with the multiple and complex problems which young people have in addition to their drug use, and are not sufficiently aware of the developmental dimensions of adolescents. Many young people will not become involved in drug treatment programs because they do not feel comfortable when they have to mix with an older population or do not want to be identified as a drug addict or abuser. Many adolescents are not likely to commit themselves to highly structured residential programs. They do not have the motivation or patience required to remain within a treatment program twenty-four hours or eight hours per day. Often they feel stifled, repressed and powerless; as a result, they often leave, preferring to seek their own solutions in the street.

A Comprehensive Approach to Drug Abuse Among Adolescents

It is clear that young people who abuse drugs have a wide variety of motivations for using drugs, have a diversity of needs and potentials, have many patterns of drug abuse and experience different consequences of drug abuse. In view of this, it is important that the approach to the adolescent drug abuse problem be comprehensive with prevention, early intervention, treatment and rehabilitation components. Programs designed for adolescents should be easily accessible and have a wide variety of resources available to deal with both the causes and effects of drug abuse as well as to help young people accomplish the developmental tasks of adolescence and find meaningful alternatives to drugs.

The Door - A Center of Alternatives, a community-based, comprehensive multiservice center for youth between the ages of 12 and 21 located in New York City, has developed an adolescent drug treatment program which is designed to address many of the problems inherent in working with a drug abusing adolescent population as well as with those at risk of abusing drugs.

In order to deal with the difficulty of reaching young people, especially those with drug problems, The Door provides a wide range of easily accessible services, programs and activities to young people between the ages of 12 and 21. To insure ease of access, all of the services, programs and activities are provided free of charge, no parental consent is required, and confidentiality is assured. The Door is a community-based youth center which is easily reached by public transportation and has been designed to be attractive to youth. The professional services available include general Medical Services, Family Planning and Sex Counseling, Nutrition Counseling, Psychiatric Services, Social Services, Legal Counseling, Education Counseling and Vocation Counseling. The availability of a wide range of human service professionals, including physicians, nurses, sex and family planning counselors, nutritionists, laboratory technicians, pharmacists, psychiatrists, psychologists, social workers, lawyers, and education, job, drug and alcohol counselors, makes possible a "total person approach" in which the multiple and complex problems which youth experience are dealt with in a holistic and humanistic manner. By including those services relevant to youth in one facility, it is possible to facilitate continuity of care and the integration of service and to avoid fragmentation and the need for referral to other agencies. Through these services the basic areas of breakdowns in a client's life can be dealt with and resolved in a practical as well as a therapeutic manner. This allows the resolution of life crises to become an opportunity for personal growth as well as for life stabilization. Only by resolving basic life problems or needs can further levels of insight and growth be facilitated.

The services available at The Door have been developed within the context of a therapeutic milieu which provides opportunities for personal growth, recreation, creative expression, as well as educational and vocational development. The Learning Center is staffed by teachers, education counselors, and a librarian/media specialist who provide supplementary educational assistance to youth who are experiencing difficulty in school and an alternative education program for youth who have dropped out of school. Creative and Vocational

Training Workshops provide young people with opportunities to explore their own potentials for creative expression, to develop work-related skills and to gain a sense of confidence and self-esteem. Workshops are available in carpentry, jewelry, sewing, pottery, photography, video-tape, graphic arts, painting, drawing and sculpture, as well as performing arts classes in music, dance and theatre. In addition there are Recreation and Sports activities and Eastern Martial Arts classes in Tai Chi Chuan, Aikido, Jiu Jitsu and Tai Kwon Do. The therapeutic milieu of The Door provides and opportunity for young people to relate with peers and adults in a contructive atmosphere of respect and trust, in addition to learning skills and developing problem solving capabilities which will help them to achieve their full human potential.

All the services and activities at The Door function as points of entry or doorways into ongoing intensive programs including the Drug and Alcohol Treatment Program, The Intensive Psychiatric Treatment Program, and the Prenatal and Young Parents Program. Through involvement in these programs, young people can participate in an intensive, ongoing process of therapy and rehabilitation, change of negative and self-destructive patterns of behavior, resolution of personal and interpersonal problems, exploration of life directions, learning and self-actualization.

An important feature of The Door is that the staff are experienced in working with adolescents, and enjoy and want to work with them. The staff are innovative, flexible, concerned, and caring individuals who are respectful of young people and are sufficiently mature and resolved within themselves to challenge and guide young people. In addition to approximately 65 clinical full-time staff, there are approximately 55 students from various professional disciplines in field placement at The Door, as well as approximately 50 professionals who volunteer their services.

By offering help in resolving those problems which young people see as important, by helping them develop the skills they need for effective and constructive functioning in society and by providing them with something meaningful to do and relieving their boredom, The Door has been effective in reaching and involving in ongoing programs a large and diverse group of inner-city adolescents, many of whom use drugs.

All young people utilizing the services, programs or activities of The Door have a comprehensive, psychosocial history taken which includes exploration of their living situation, family, adult and peer relationships, school and work history, medical, psychiatric and nutritional history, sexual history and legal history. As part of this exploration there is an inquiry into the extent of drug and alcohol use, the effect of this use on the young person's life and the motivation for this use. An important aspect of the assessment is the determination of the young person's insight into the effects of drug use and his desire to change the extent of his use of drugs.

The psychosocial exploration makes it possible to identify those young people for whom drug use is having or potentially could have a detrimental effect on their lives. Depending upon the degree of insight they have about these effects and the motivation they have to change the extent of their drug

use, young people can be involved in one of two drug treatment programs available at The Door, the Crisis Intervention and Short-Term Treatment Program, or the Intensive Treatment Program.

The Crisis Intervention and Short-Term Treatment Program

Those young people who are not willing to identify themselves as drug abusers or to admit that their drug use is having a detrimental effect on their lives can be engaged in The Crisis Intervention and Short-Term Treatment Program through their use of services and activities which they see as most relevant to their needs and interests. Though they themselves, do not acknowledge the effect of drug use on their lives, the help these young people receive in resolving problems and life situations is important in preventing increased involvement in drugs and in treating symptoms related to drug use and the causes underlying their drug use. The emphasis is on crisis intervention, resolution of problems and conflicts, and involvement in alternatives before drug abuse becomes a central life focus.

Each staff person plays a key role in linking a young person to The Door, involving him in the therapeutic milieu and helping him to gain insight into his drug use. While helping to solve those problems which the young person sees as important, the staff person comes to be trusted and valued by the young person. Within the context of this supportive relationship, the staff initially can help the young person to understand that many of his life problems either contribute to or result from his drug use and eventually can challenge and motivate him to decrease or discontinue his drug use.

As part of their therapeutic program, young people are asked to take part in Life Education Workshops in which they discuss themes relevant to adolescents such as interpersonal communication, human sexuality, relationships with family, peers and adults, dealing with guilt, fear, anxiety, loneliness and anger, dependency, responsibility, identity, change, school, work and creativity. The ramifications of drug abuse in relation to these themes is thoroughly explored. Specifically drug-related themes include the effects of various drugs, the costs of drug abuse, the exploitation of youth by advertising, peer and other social pressures leading to drug abuse, and legal implications of drug abuse. The aims of involving young people in these workshops is to help them understand the adolescent developmental process which they are going through, to support them at this critical time, and to provide opportunities to gain further insight into their own drug use. Ultimately it is hoped that they will be motivated to use drugs in a more responsible manner or to actively decrease and discontinue their drug use.

Following their involvement in The Crisis Intervention and Short-Term Treatment Program young people may become involved in the Intensive Treatment Program or may terminate their involvement with an option to return at a later time for additional help or a more intensive involvement.

The Intensive Treatment Program

The Intensive Treatment Program provides structured long-term involvement for young people who acknowledge the effect of drugs on their lives and are

motivated to decrease or discontinue drug use. This program focuses on youth ranging from those who are regularly abusing drugs and whose life activities and functions have been disturbed but not completely disrupted by their drug use to young people who have suffered serious disability from extensive drug involvement, whose energies are almost completely consumed by the "drug life." Special emphasis is placed on the psychiatric treatment of those youth who are using drugs as a response to a variety of underlying psychiatric problems ranging from adolescent crisis and depression to psychosis and other severe mental disorders and for whom drug use often represents an attempt at self-medication, and on the treatment of delinquent youth who abuse drugs as part of an antisocial life-style.

Young people who are currently addicted to drugs and require detoxification before they can enter The Door's program are referred to nearby detoxification services with which backup relationships have been developed. Youthful drug abusers whose psychological or physical condition is so unstable that they require inpatient hospitalization are referred to backup psychiatric and medical hospitals for intensive treatment and preparation for ongoing treatment in an outpatient or ambulatory setting. Young people without sufficient motivation or inner strength to resist drug use in an open setting while living in the community are helped to enter a residential drug treatment program appropriate to their particular needs.

Following an initial period of orientation, an individualized treatment program is developed for each participant which includes definition of specific treatment goals appropriate to his needs and interests. The program includes group psychotherapy, family counseling, utilization of specific services for resolution of dysfunction in defined life areas, comprehensive medical care, nutrition counseling, "community" meetings, life education workshops, education and vocationally-related counseling, classes or workshops, creative workshops, and physically-related activities in sports, martial arts or dance. In addition, there is individual counseling with the young person's primary counselor who oversees his involvement in the various services and activities at The Door. Participants are expected to follow the individualized program which is changed as therapeutic progress is made. The individualized treatment program is designed to deal with the young person's specific life situation, problems and needs, to draw on his individual potential and strnegths, to provide supports and challenges, and to involve him in a change- and task-oriented therapeutic milieu which can help him to deal with his patterns of drug abuse as well as with the underlying and related psychological, social and family issues and problems.

The primary therapeutic modality employed by The Door is milieu therapy. Within the context of the overall therapeutic milieu individual and group modalities are used to explore with the young person, in the context of his peers, his life reality, his behavior and his interaction within the milieu. In this way the therapeutic approach is concrete, pragmatic and reality-oriented. The day-to-day activities of the client within the dynamic setting of the milieu and within his own community provide the material for feedback, understanding, insight, exploration and experimentation with new modes of behavior and interaction. Crises are seen as opportunities for learning and

growth within the supportive environment. The therapeutic milieu provides for a corrective learning situation where positive interaction, constructive behavior, problem-solving, self-expression, responsibility and independence are encouraged and reinforced.

Within the milieu there are several underlying themes which must be accepted by clients who enter the program: that drugs and alcohol are not allowed within the program; that violence is not allowed; that the program requires active involvement in workshops, services, therapeutic sessions and other activities; that it is a place for problem-solving, growth and change; that it is a place to learn about oneself and one's relations with others; and that it is a community.

The therapeutic milieu of the program also provides a sense of human warmth and belonging which is usually absent in the lives of many of these youth. Frequently the isolation and alienation they feel has been a major factor in leading them to drug abuse. Since many of the clients treated in the program do not have a family, the feeling of family which they experience within the community of The Door has a supportive and healing effect. The group projects and participation in a constructive and supportive peer group provide a sense of direction while the young person becomes secure in his own identity and values.

Prevention of Adolescent Drug Abuse

In order to develop a truly comprehensive approach to adolescent drug abuse, it is important that a significant amount of society's efforts and resources be placed on the development of innovative and effective strategies for prevention of drug abuse. These strategies will have to go beyond traditional dug prevention and education efforts, for the lack of information regarding the harmful effects of drugs is not the main reason why individuals abuse drugs. Prevention efforts should aim at helping individuals to resolve those problems or life conditions which frequently foster the use of drugs, providing positive alternatives to drug abuse and helping them to lead constructive and satisfying lives without the need to use drugs.

Two important target populations for prevention approaches are the preadolescent and adolescent age groups, for it is during these age periods that drug-taking behavior is first learned. By preventing young people from acquiring dysfunctional drug-taking behavior, there will be considerable reduction in later suffering, hardship and loss of productivity which affects both the individual and society.

It is important that sufficient financial resources be allocated to develop innovative and effective prevention programs. Prevention should not be seen as an easy or inexpensive way of resolving the drug problem. The problem is complex and there are no "proven" guidelines for prevention programs. The problems or life situations underlying drug use are not easily resolved and may take time for their resolution. However, the cost for a prevention effort is expected to be significantly less than the long-term costs to the individual and society resulting from drug abuse.

Although The Door receives funding for drug abuse treatment, special attention is given to young people who have only recently begun to abuse drugs and to those who appear at risk of abusing drugs. The Crisis Intervention and Short-Term Treatment Program, which was described earlier, is used to deal with those young people who have only recently begun to abuse drugs. The Door utilizes a variety of prevention strategies for those young people who are at risk of abusing drugs. The majority of these young people do not see drugs as a problem in their lives and seek The Door's services, programs and activities for other reasons. In order to demonstrate why young people initially attend The Door, and what they perceive as important to them, we have included a number of statements made by young people in response to the question, "What are your reasons for coming to The Door?" These statements have been clustered as they relate to involvement in the drug abuse prevention strategies available at The Door.

1. Life Skills

Because I think The Door is an advantage for my future. The Door offers things I am interested in. (Age 15 years)

I heard that it was a really nice place to come and learn and to meet people. (17)

To learn skills I do not know. (17)

I would like to get myself together. (15)

I have been to good schools but could not adjust. Now I know it's time to. (19)

I would like to learn how to deal with my problems at home. (15)

To get my head together and be something when I get older - instead of a adict like my friend. (18)

To expand my knowledge and make my life more interesting. (17)

To try to improve myself. (15)

To learn self- defense in order to protect myself or family in the streets. (13)

To learn about different skills and to have a better understanding with them. (14)

Meet new people and expand my knowledge. (19)

Much human misery appears to be the result of a lack of competence; that is, a lack of control over one's life and of effective coping strategies and the lowered self-esteem that accompanies these deficiencies.[2] Competence building is perhaps the single most persuasive preventive strategy for dealing

with individual and social issues in most communities. In addition to promoting individual competence and mental health, preventive programs can help to build "competent communities;"[3] i.e., the provision and utilization of resources so that members of the community can make sound and appropriate decisions about issues confronting them, leading to the most "competent" coping with these problems. To this end, The Door offers "workshops" in decision-making, values clarification, youth "awareness" raps and works with other agencies and community people to solve "community" problems.

2. Social/Interpersonal Skills

To socialize among my peers and maybe earn some respect and acceptance. (Age 18 years)

Interested in rap sessions. (16)

To get all the help possible in getting my relationship together with my boyfriend. (15)

I have interest in people who need people. That's why I'm here to learn new things and share the bit I know. (19)

To meet new people and have something to do with people and myself. (17)

To be around good people. (17)

Mingle with people. (16)

Lack of things to do at home (sports, etc.) and a touch of loneliness. (15)

I'm so depressed and lonely - can't take wandering around and going places alone anymore. (18)

To learn different things and meet different people. (15)

I would like to meet people my age. (13)

The ability to develop and maintain meaningful and healthy human relationships is a strong deterrent to drug abuse. When social skills are enhanced, improved social adjustment occurs. Self-esteem can also be increased by enhancing social and interpersonal problem-solving skills.[4] The Door offers effective education, theme-centered rap sessions, therapy groups, men's and women's groups, "social communications" groups and activities such as holiday celebrations, outings, camping trips and other "social" events to provide young people with opportunities to learn social skills, to try out new behaviors at The Door's and in the community and to develop meaningful friendships.

3. Recreation, Leisure and Creative Involvement

I have a lot of spare time after school because of no job and would like to learn more things. (16)

Because I want to get back to ballet and jazz since the P.A.L. is closed for the summer. I want to study here. (12)

To have something to do with my spare time instead of waisting it and getting maybe in trouble. (15)

To occupy my time after school creatively instead of hanging out in the streets and getting in trouble. (16)

The need for something constructive to do this summer. (16)

I want to develop the talents within me. (17)

I wanted to get into a field I could work at not just school work. (16)

My reason is to have fun. (12)

To spend time doing something that I like. (13)

To make use of myself, to have something to do instead of laying around. (14)

There is nothing to do around my house and my brother told me I should join The Door. So I am. (12)

Recreation, Leisure and Creative Involvement provide activities that are designed to promote growth and wholeness and to help people make maximum use of their potentials, independently of whether they already are troubled or "ill." Young people often feel bored and do not have ways to fill their leisure time constructively. "Fun" is really fun when no one gets hurt or suffers. Included here are activities which can provide emotional outlets, ways to constructively channel one's energies, as well as ways to feel good about one's own achievements through "creative" projects and learning the arts. Many of the previously mentioned activities which The Door offers, provide opportunities for fun, enjoyment and learning.

4. Social Support/Group Support

Because I really need someone to talk to. (Age 16 years)

Because I need some counseling, and pregnancy test, and job help.

I have problems at home with my mother and I want to get out the house. (16)

Schoolastic (psychological conflicts - HELP!! (18)

A teacher in school referred me here because of family problems. (14)

Was told I could get help with confusing legal problem. (16)

I have to talk with someone. (16)

I would like to learn how to deal with my problems at home. (15)

Help with my living situation since my mother died. (17)

Because I want someone to help me understand what everything is all about and why it's unfair sometimes. (17)

For help in parenthood and problems. (17)

Because I don't know someone who can help me. (18)

I wanted to talk to someone about some difficulties I have in general just to see what this program was about (16)

To get help when I need it. (15)

I need help desperately (school, home, jobs). (14)

I'm just trying to avoid problems at home and to get them off my mind!! I would also like to meet people (like me)!! (14)

Because I'm having problems at home with my father, who's an alcoholic, I need counseling on how to cope with him.

To get help with my emotional problems. (12)

Susceptibility to drug abuse is much lower in persons who have strong group and social support and far higher in persons who are deprived of meaningful social contacts or counseling. In many intances, the family should, but often fails, to provide the necessary support system for young people during the "turmoil" of the adolescent stage of growth, and more particularly during times of crisis. In lieu of the family, the availability of crisis-intervention and counseling services or social supports during times of great stress have a positive effect on an individual's mental health and general health and may prevent a variety of forms of dysfunctional behavior, particularly drug abuse. When possible, prevention programs can provide services that may strengthen the family unit through parent effectiveness training, family life education, family counseling, etc., thereby helping to build on the potential of existing support systems. The Door offers crisis-intervention services, individual and group therapy, couples therapy, family counseling, as well as groups for young people who have parents with alcohol or drug problems.

5. Client Involvement and Youth Leadership

I would like to help out any way I can.

By starting out in your program and then helping others. (16)

I can do calligraphy for signs. (18)

Working with younger children in education. (14)

Teaching little children about the Bible. (14)

I'm a good story-teller. (19)

I'm artistic and can do photography. (17)

I would like to share what I know about arts and music. (15)

To learn from others and they can learn from me. (15)

More self-support. Then I could help others. (19)

To help other people who need help. (18)

To do something with my time - to help out somehow (in the cafeteria). (14)

The success of any prevention program is partly dependent upon active recipient involvement. The young person can play a role in removing barriers to health by offering ideas on how he can be helped, by providing insights into the sources of life stress and by participating in the process of growth-enhancement and achieving well-being. Adolescents frequently are searching for opportunities for commitment, for being a part of something, for contributing to society and for helping and giving to others. At The Door, young people are encouraged to help out; they experience The Door as their place and their contributions (which can range from helping with clean-up, with decoration and renovation of the facility, with meal preparation, to developing leadership and peer advocacy skills in a youth worker training programs) is valued. Young Door members also participate in community meetings and in The Door's Community/Consumer Advisory Board. Young people themselves have also organized youth fairs, open houses, a Door newsletter, and "Energy Fair" and other youth-oriented events.

6. Individual Identity and Cultural Identity

Questions. (14)

To get it all together. (13)

I am interested in bettering myself mind and physical wise and I heard this is where I can do that. (15)

To know more about myself. (15)

To know more about myself. (13)

Very confuse. (19)

To become involved in a meaningful program. (13)

To learn more about what I want. (16)

I feel like people are not recognizing me for what I am. (17)

To find myself and keep busy. (17)

To find out more about myself and to join some activities.

Preventive approaches which recognize and accent the uniqueness which exists within a given ethnic/cultural group, as well as the unique qualities of each individual, while at the same time promoting opportunities for sharing cross culturally can enhance and restore pride and dignity and can enable young people to utilize cultural and spiritual insights in their lives. Preventive programs which are sensitive to the changing roles of women and men in our society can help young people develop an identity which is secure while remaining flexible and able to adapt to changing social forces.

The Door offers young people a variety of group experiences and projects which enhance individual and cultural identity: men's and women's groups, ethnic and culturally oriented events (which promote Black, Hispanic, Oriental and Native American awareness), as well as projects which offer opportunity for young people to express directly their "cultural" concerns. An example was a recent campaign to help hurricane victims in the Carribean which was organized by a group of Dominican young people at The Door yet was carried out by a "multi-ethnic" group of teenagers. Preventive approaches which promote a sense of identity can counteract the effects of discrimination and racism in individuals and eventually lead to an atmosphere of mutual understanding, sharing and working together in communities. The Door's Learning Center offers ethnic studies classes and workshops for Black and Hispanic young people. The Door has recently developed a liaison with the American Indian Community House in New York to provide services to young Native Americans with substance abuse problems. The Door has "Identity" groups for young people who do not have specific problems, but who are searching and want to explore their lives and life-styles.

7. <u>Physical and Mental Health Education Services</u>

I need help because I think I'm sick physically. (Age 14 years)

For Birth Control. (15)

I am interested in bettering myself mind and physical wise and I heard this is where I can do that. (15)

Because I need some counseling, and pregnancy test, and job help.

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I need a place for my afternoons and to lose weight - shape up. (15 1/2)

To find out about birth control. (17)

For some type of protection (birth control), and I also heard about the different types of workshops The Door offers and I came to look into it. (16)

Information and questions about angel dust and acid. (16)

I came to The Door to stop smoking. (16)

For help in parenthood and problems. (17)

To stop using angel dust before it's too late and to take dance lessons. (10)

To have karate lessons (martial arts) and because I can learn from this experience. (13)

My reason is because I never had a chance to go for gymnastics and now I can go with my cousin. (14)

I want to come because I want to learn the arts of self-defense.. (13)

Health Center, free, warm atmosphere. (16)

I think I might be pregnant. (14)

Prevention approaches which include services and activities that are designed to encourage holistic as well as specialized views of the process of health and of a healthy life, can promote physical and mental "well-being" for young people. These approaches must take a broad view of health as not only the absence of disease but also the presence of joy in living and hope in the ultimate resolutions of life's conflicts. In addition to the health and mental health services available, The Door has a Health Advocacy Program in which specially trained youth provide health information and education services. They utilize audio-visual media and rap sessions to explore a variety of health-related topics. They conduct workshops in relaxation and stress-reduction techniques, a hypertension screening project, a "smokeless" program for peers wanting to reduce or cease cigarette smoking, a jogging exercise class, drug and alcohol education, and sexuality education for peers.

Other activities, such as exercise classes, weight reduction classes, gymnastics and body building, as well as martial arts (Tai Chi Chuan, Karate and Aikido are offered) help integrate body, mind and spirit.

8. <u>Career Planning and Educational Assistance</u>

To take my equivalency. (19)

I came to the door because I was hoping that they could help me find a job. (16)

Because I wanted tutoring and gymnastics. (14)

Schoolastic (prychological conflicts - HELP!! (18)

I used to be a member and now I want to make my involvement and use of your facilities a more constant thing - especially since the start of school problems. (17)

I would like a chance to become a good worker.

Getting me into a nice career or Training. I work day and want to still study. I want to have some kind of education. (18)

To learn. (18)

I was looking for a job and I call up this place, "jobs for youth" and they told me to come here. (17)

I need two Health Ed credits to graduate in June. My guidance counselor told me to come here.

They sent here from my school for some gym credits. I need to graduate. (18)

I need a job badly. I have 2 yr old son I saw the ad in the newspaper and I think what better way to get a job & a training at the same time. (18)

I plan to make a future for myself and the first step to doing that is to get my H.S. Diploma.

My legal aid sent me for reading and math. (15)

Interested in tutoring one to one. (15)

The Door provides career counseling which can help adolescents focus on long-range goals, as well as help them prepare for entering the job market. Vocational training workshops provide young people with the needed skills to gain employment. The Door also provides tutoring in basic education skills, preparation for the G.E.D. and help with reading and math and other subjects. Individualized attention and support and "small group" tutoring help young people who may feel embarrassed about their poor scholastic abilities and achievement.

9. Alternatives

My present environment and daily habits are killing my will to live. (Age 19 years)

To not be drinking and smoking like all my friends. (15)

I came to The Door because I think it's better than fighting in the street. (16)

So I can enjoy myself, help improve subjects and stay out of trouble. (13)

A lot of spare time - nothing to do but get high. (18)

I need someplace to keep me occupied. (17)

I'm not attending school and I want to try to stay out of trouble and try to get a decent job. (18)

Because my sister is here and she told me it's a good place. (12)

To get away from hanging around people that live around my way. (15)

To get help in alternatives. (13)

I was bored at home. (13)

I rather be here than in the street doing no good. (15)

To check things out and see what I can do of interest. (13)

I was told about it and I thought it might help me. (16)

I came because I have problems at home and I need a place to come to relax and take those problems off my mind. (17)

Things weren't working out around my environment, with girls, and at home. I'd been puffing angel dust for 3 years and now I've stopped. (17)

I just lost my job which took up a lot of time, so I needed something to cover up for it. (15)

Positive alternatives which can effectively prevent drug abuse are activities which are perceived by young people as relevant to their needs, interests and goals. They should be easily accessible, visible, initially easy to participate in and explore, and ultimately satisfying, rewarding and meaningful. Many young people come to The Door looking for something which is better than or more satisfying than "hanging out," "staying at home," "getting stoned." Frequently young people have difficulty articulating their actual needs, while at the same time they do express an interest in specific activities which they perceive as having some value or seem attractive to them. Some just say they're here to "check things out."

Mr. WAXMAN. Thank you very much.
Rabbi Friedman, if you would proceed.

STATEMENT OF RABBI MURRAY I. FRIEDMAN

Rabbi FRIEDMAN. Honorable Chairman, and members of the congressional subcommittee:

My involvement in the field of drug abuse prevention and intervention is manyfold. However, I am here principally as chairman of the New York City Council of Substance Abuse Prevention/Intervention.

The council is a coalition of eight community-based prevention/intervention programs, and three programs based in the nonpublic school sector. The names of the councils are:

The Archdiocese of New York; Boys Harbor; Children's Aid Society; Chinatown Planning Council; Diocese of Brooklyn; Educational Alliance; Harlem Teams for Self-Help; Hebrew Day Schools; Resurrection Youth Service; United Bronx Parents; and The Harlem Branch of the YMCA of Greater New York.

Some of the directors of these programs are here with me today.

Together these programs serve a cross section of the ethnic groups in all five boroughs of the city. Thus, the council symbolizes the common spirit of these programs which, although diverse in their ethnic and geographic features, are united in their determination to conserve human lives and produce useful citizens.

I guess you will not think me presumptious that you have already reviewed the written testimony which I submitted in advance of this hearing. I will use this opportunity, consequently, to touch but briefly on the several theses which this document contains, and not burden you with a repetition of arguments already made known to you.

The council firmly believes that intervention or early intervention, as it is sometimes called, is a preferred and most efficient modality for dealing with substance abuse. Intervention pursues a course of moderation. It avoids the dissipation of effort of prevention programs, on the one hand, and on the other hand, it reaches the abuser before he advances to the stage of dependence and requires intensive treatment.

Intervention, it must be emphasized, has a defined target population, and a specific design for evaluation. The population is comprised of the unhabituated drug abuser and the individual who exhibits behaviors that are proven predictors of drug abuse, such as truancy, chronic failure, or social maladjustment. The evaluation process is designed to measure the changing pattern of these behaviors.

Intervention programs vary considerably. Some form of counseling, whether it be with an individual client, a group or the family, is common to all intervention programs. There is considerably diversity, however, in the techniques that are used to bring the client to a counseling setting. The inducement may be a supportive setting, recreation, field trips, or opportunity for mediation. This versatility is especially important in bringing services to the school dropout population.

Intervention programs recognize that substance abuse represents a continuum, beginning with prevention programs for the still

uncontaminated individual, and terminating with treatment facilities for the almost hopeless addict. Thus, there is a need for programs to reach across this entire continuum, programs located in the schools and programs located in the community.

It is vital, moreover, that linkages be maintained among these programs so that the client out of the reach of one, will receive care from the other.

Models of intervention programs can easily be replicated in other parts of the country. There is at present a sufficient reservoir of experience and expertise within the programs represented by the council, which can be tapped by communities and school systems that have the willingness to mount such a program.

The New York State Division of Substance Abuse Services has nurtured and encouraged intervention programs and is unquestionably a resource in this area.

The council acknowledges the recognition given to intervention by the House of Representatives through its insistence that a portion of all Federal drug abuse funds be expended for prevention/intervention purposes.

The council has steadily maintained that the policy of the National Institute on Drug Abuse to channel its funds into treatment services or research was arbitrary and counterproductive.

By almost any index, the increase in drug abuse is a source of deep alarm. Precise statistics on this trend are available from the excellent reports issued by the Bureau of Cost Effectiveness and Evaluation of the Division of Substance Abuse Services.

The general summation is that drug abuse reaches every segment of the population, penetrates all racial, ethnic, age, economic, and social groups. Illegal drug abuse threatens to embed itself in the lifestyle of society. As recognition of this condition mounts, traffickers and users of drugs are more brazen in their practices.

Intervention programs resolve the fragmentation of services that exists within agencies, existing for the benefit of the marginal members of society. Unification contradicts most categorization of problematic behaviors. Uniservice programs should command resources to deal with the individual as a whole, to think of him not as a drug abuser, an alcoholic, a dropout or runaway, or delinquent, but rather as a human being who is suffering from a complex disorderly behavior, and needs to be treated by a single agency.

Intervention programs see drug abuse as a symptom of underlying social defect, and affirm the need to examine the basic causes of drug abuse and other negative behaviors which reflect this morbid condition.

Unless the problem is attacked at the roots, no amount of legislation and no amount of appropriations will enable government to keep pace with the rise of drug abuse.

I trust that this brief statement serves as an ample review of the more detailed testimony which was submitted to the committee.

I will be pleased to answer or call upon my colleagues to answer questions which you wish to raise. It is my hope that the initiative and leadership which this subcommittee has demonstrated through this hearing and its other activities will serve as a stimulus to governmental bodies and communities across the country, and that,

with God's help, we will see a quick end to this depressing play, and, of much greater moment, the healing of the underlying social maladies of which drug abuse is but one symptom.

Thank you.

[Testimony resumes on p. 128.]

[Rabbi Friedman's prepared statement follows:]

New York City Council of
Substance Abuse Prevention/Intervention Programs

Submitted by Rabbi Murray I. Friedman

I am Rabbi Murray Friedman.

Like Joseph in the Bible, I wear a coat of many colors.

I am program director of the prevention/intervention program conducted under the auspices of the National Society for Hebrew Day Schools. The program is funded by the New York State Division of Substance Abuse Programs.

I am chairman of the New York City Council of Substance Abuse Prevention/Intervention Programs. I shall have more to say about the activities of the Council later on in this testimony.

I am a member of the Governor's Advisory Council on Substance Abuse, a body which owes its formation to a mandate of the New York State Legislature. I also serve on the Policies Committee of the Council.

I am co-chairman of the recently formed Clergy Committee on Substance Abuse, an independent body of clergy in the substance abuse field which was encouraged into existence by the State agency.

I list these affiliations not with the intention of vaunting my own deeds but rather to lend credit to the testimony which I am about to present. I believe that my broad range of experience in the field of substance abuse authorises me to speak in behalf of a large sector of the substance abuse community rather than as an individual.

Let me begin with a brief description of the New York

City Council of Substance Abuse Prevention/Intervention Programs, for it is primarily as chairman of this organization that I am privileged to present this statement.

The Council is a coalition of nine community-based prevention/intervention programs and three programs based in the non-public school sector. The members of the Council are:

Archdiocese of New York
Boys Harbor
Children's Aid Society
Chinatown Planning Council
Diocese of Brooklyn
Educational Alliance
Harlem Teams for Self-Help
Hebrew Day Schools
Resurrection Youth Prevention
United Bronx Parents
YMCA of Greater New York (Harlem Branch)

Together these programs serve a cross-section of the ethnic groups in all five boroughs of the city.

For the past ten years these programs have demonstrated their effectiveness through the use of a variety of strategies and methodologies. Intervening at an early stage, they have rescued many thousands of school age children and young adults from a life of misery and despair. The Council symbolizes the common spirit of these programs which, although diverse in their ethnic and geographic features, are united in their determination to conserve human lives and produce useful citizens.

The Council is the collective voice of the constituent

programs and also an instrument for self-analysis and the exchange of information and ideas. It provides a forum for program directors to submit their ideas and operations to the scrutiny of their colleagues so that there is a constant refinement of theory and technique. Overall strategies and more efficient programming are also developed by the Council and periodically evaluated. Because of its committed membership, the Council enjoys a semi-official status with respect to the State agency and meets monthly with representatives of the agency to work side by side toward shared goals and objectives.

Why this lengthy introduction? In order to accentuate that the views expressed in this statement are the product of many, many hours of deliberation by a group of individuals with differing perspectives and differing points of view. Over the years the sentiments of the group have coalesced and assumed a collective quality, and it is the sense of this commanality of judgments that I present before you on this occasion.

The Council, during its relatively short history, has a number of concrete achievements to its credit. If I were asked, however, what I consider to be the chief accomplishment, the reply would be not in terms of a definite objective but rather in terms of an attitude. I allude to the modality which goes by the name of "intervention," a kind of service which I call the "ugly duckling" of the substance abuse field. Early in the days of government involvement in drug abuse two modalities were acknowledged, prevention and treatment, and two monolithic organizations became identified with them: prevention became the domain of the public school system and treatment the domain of the therapeutic communities. Between these two giants there sprang up, after a while, a number of smaller programs,

some community-based and others conducted in the non-public schools. These programs occupied a limbo of their own, neither clearly prevention nor clearly treatment, neither part of the public school system nor part of the therapeutic communities. The vulnerability of these programs was demonstrated repeatedly as time and again they were called upon to defend their right to exist and to prove that they, too, ought to occupy a "place in the sun."

But from adversity came solidarity and from solidarity came a sense of identity and a unity of purpose. No, these programs declared, we are not prevention. The prevailing concept of prevention was a program of general education, utilizing instructional techniques, designed to develop an awareness of the dangerous consequences of drug abuse. The target population for this modality was indefinite, its methodology ineffectual and sometimes causing reverse effects. The new programs, the intruders, rejected this function.

No, they also declared, we are not treatment programs either. Treatment is for the addicted and the dependent. Why wait for the drug abuse victim to degenerate to the stage where only intensive therapeutic techniques can effect his rehabilitation? Is it not eminently more sensible to set as one's target the individual who is at the incipient stages of drug abuse, who is identifiable as a likely candidate for addiction or dependence unless he is given assistance while in his present condition? Thus the treatment function was rejected as well.

Out of the striving to avoid the defects inherent in prevention and treatment a new modality was born: intervention. Intervention programs are chiefly on the alert for the individual who is experimenting with drugs

and is on his way to becoming an abuser, but they are also looking for the school dropout who, if not already familiar with drugs, will ineluctably become part of the drug abusing population; for the chronic school failure who nurses his ego wounds received in the classroom in the company of other sulking, rebellious youths like himself; for the drifter, the floater, the depressed, and other socially maladjusted individuals who will eventually seek a chemical solution for their personal dysfunction; and for the member of the family who is as yet uncontaminated but must live in a setting where a brother or a sister, a mother or a father, has already succumbed to drug abuse. With limited means and resources, intervention programs heroically attempt to fill the enormous lacuna resulting from the inadequate range of the prevention and Therapeutic programs.

The crystallization of the philosophy of intervention programs made it possible to counteract a frequently leveled criticism. Over and over intervention programs have been pressed to answer the question: How do you know that your service to the client has effectively deterred him from becoming a drug abuser? There is now an adequate response to that question. Intervention programs deal with behaviors that, in the light of scientific research and tested experience, are predictors of future heavy involvement in drug abuse and dependence. The experimenter, the dropout, the resentful chronic failure, the gang member, the member of the drug-using family - for each of these individuals there is a salient statistical probability that inevitably he will become infected with drugs. And for each of those behaviors there are specific techniques for detecting measurable changes. Granted that intervention programs do not possess the laboratory means to determine

improvement such as are available to treatment programs, they do possess on the other hand, far more refined techniques than those that are available to the conventional prevention programs.

How do intervention programs achieve their objectives? There is no unitary answer to this question. Because they are so intimately involved with the communities which they serve, intervention programs assume a wide variety of identities in response to the needs of the population which they serve. Whereas counseling may be regarded as a common thread which runs through virtually all intervention programs, there are considerable dissimilarities in the methods that are employed to encourage the client to enter into a counseling relationship. The inducement may be a supportive setting, group activities, athletics, field trips, or any other incentive which a program may deem useful for drawing clients to its doors. There is flexibility, too, in the counseling process itself. Individual, group, or family counseling may be employed, depending upon the needs of the clients and the orientation of the program. School-based orientation programs, although in a better position than community-based programs to establish contact with the client, also use a range of techniques which are appropriate to the students whom they service.

I wish to recur now to the "ugly duckling" analogy which I mentioned earlier. Once intervention programs formalized the philosophy and methodology of the modality, there was a remarkably rapid acceptance of the intervention's rationale and process in substance abuse circles. Workers in the public school system openly avowed that although their programs were designated as "prevention" their

actual activity fell under the category of intervention. Treatment programs, too, became more favorably disposed toward this newcomer. As the census of heavily addicted clients began to decline and the number of less-than-addicted registrants began to rise, treatment programs became increasingly uneasy with the strictures placed upon them by legislative regulations and expressed a wish to be permitted to service intervention clients as well. Perhaps the most outspoken praise for intervention programs is to be found in the "1980-81 Update" of the "Statewide Comprehensive Five Year Plan" published in October, 1979, by the New York State Division of Substance Abuse Services which states (p. 5) that "the most effective way to reduce the spread of substance abuse is to prevent those at risk from becoming substance abusers." For reasons which are irrelevant at the moment the explicit use of the term "intervention" is avoided, but there is no question that the sentence is a laudatory statement about this modality.

There is one compound, however, where intervention has met with blunt resistance. I refer to the National Institute of Drug Abuse, commonly known by its acronym, NIDA. I do not cease to wonder that despite the fact that the proceedings published by Congressional committees are replete with passages that extol the value of prevention - which in Congressional language also includes intervention-type activities - NIDA has rigidly insisted on fixing its funding guidelines in such a manner so as to exclude all programs except those that treat the heavily addicted client. It is certainly not my intention to question the need for treatment programs. I believe that I have as much compassion as any other individual FOR THOSE whose very existence is annihilated as a result of his enslavement to the drug habit. I do marvel, however, that the people at NIDA, highly competent individuals,

do not recognize that it is utterly irrational to expect that the spreading tide of drug abuse can be reversed or even contained if federal efforts are restricted to dealing with clients who are in need of intensive rehabilitation. I wish to commend, therefore, the efforts that are now being made in Congress to mandate without equivocation that a portion of federal funds allocated for the control of drug abuse be expended for prevention purposes, which also comprise intervention programs. It is my sincere hope that the enactment of this provision will signal the beginning of an era of vigorous Congressional leadership in establishing strategies for a counter-offensive against drug abuse, and that a recognition of the central role of intervention programs will be reflected in this plan of operations.

I do hope that my ardent advocacy of intervention is actuated by an honest, objective assessment of the drug abuse picture and not by some narrow, vested interest. My purpose in presenting this testimony is to call the attention of the Congressional committee that models of intervention programs now exist which can be replicated in any location where there is an awareness in the community of an existing or potential drug problem and a willingness to commit its resources to tackle this problem. I wish to make one qualification, however. It has been my experience that intervention programs are people and not mere organizations. Because these programs have their roots in the community, because the personnel who staff these programs have more than formal interest in the clients they serve, the measure of dedication and commitment that prevails is exceptional. I urge, therefore, that in the funding of new or expanded intervention programs, intensive efforts should be made to ensure that the persons who are entrusted

with the administration of these programs are individuals who not only possess the professional competence requisite for such positions but also that they disply the spirit of idealism and the pangs of compassion which will vitalize their efforts without abatement.

My plan for greater support for intervention programs is reinforced by the recent survey of the dropout rate in the public high schools of New York City. The figure released is shocking forty-five percent. This statistic does not take into account the substantial number of pupils who do not reach high school altogether. One must also keep in mind that even of those officially attending high school a significant percentage are frequent absentees. Needless to say these youths are prime targets for the avaricious purveyors of all sorts of drugs. Who shall assume reponsibility for these youths? The schools? this institution has already met with rejection. The treatment programs? they are not designed for this purpose. It is the community-based intervention programs, sharing the same environment as these youngsters and able to gain their trust, that have the capability of handling these youngsters and enabling them to return eventually to a school program. Parenthetically, I also wish to mention that intervention programs are constantly appealing for closer linkages with public school prevention programs so that the two can work in harmonious partnership rather than as two isolated entities.

Up to this point I have addressed a number of issues which have bearing on the painful problem of drug abuse. I have not dealt with the primary concern of these hearings: namely, the changing character of drug abuse. With regard to the objective data available on this subject, I presume that the Committee is familiar with the

documents issued by the Bureau of Cost Effectiveness and Research of the New York State Division of Substance Abuse Services. In particular, I refer to the 1978 Fact Sheets on "Trends in Drug Abuse"; "Drug Trends in New York City - June, 1979"; "Heroin, Cocaine, and PCP Marketing - August 14, 1979"; and "Current Drug Abuse Trends - September, 1979." Another useful publication is the "1980-81 Update" of the "Statewide Comprehensive Five Year Plan" which was mentioned earlier in this testimony. The "Introduction" in this report summarizes in descriptive terms of drug abuse trends in New York State. It states, for example, "Substance abuse now touches the lives of all racial, ethnic, age, economic and social groups within the state." Extensive statistical data is to be found within the report itself. It would serve no purpose, therefore, to review before you information that is already available. My own contribution, rather, can be in the form of observations made by myself and gathered from other directors of intervention programs. It is an established fact that in certain parts of the city youngsters as early as the fifth grade are already involved with drug traffic. It is evident, merely from walking through the streets of New York, visiting its parks and places of entertainment, talking to persons from all socioeconomic levels, that the attitude toward the taking of drugs has become shockingly permissive. There are even individuals who head substance abuse programs that are prepared to accept drugs as part of the American life style. Others are so overwhelmed by the sheer magnitude of drug abuse that they throw up their hands in despair. I do not know of any other period in this country's history when American society was threatened by such a malignant, enervating, wasting, insidious disease. The federal response, I truly believe, must be directed not only against the use of drugs but it must also focus very carefully on the

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changing public attitude toward this social problem. Drug abuse programs cannot meet with any but limited success if the public attitude does not support their aims.

I wish to conclude this testimony with two propostions, both of them the outgrowth of the collective experience of the members of our Council. The first proposition is that government must cast a critical eye on the fragmentation of services for the deviant population. These are programs for the drug abuser, programs for the alcoholic, programs for the delinquent, programs for the dropout, programs for the abused child, and on and on. People do not come in simplistic little packages, and it is often necessary to deal with a problem that has many facets. At present such problems require the service of multiple agencies, compounding an already difficult situation with a combination of bureaucratic hindrances. Some time ago I proposed that Congress enact a Human Conservation Act which would bring about a coalescence of the various agencies whose services now impinge on the individual who is not functioning adequately in society. I repeat this proposal now and offer the resources of the Council in the structuring of such an act.

The second proposition, I believe, holds the true key to the sweeping advances of drug abuse in this country. Congress must recognize that at the present time drug abuse <u>per se</u> is only the symptom of a far more fundamental malaise that is infecting American society today. There are other symptoms of this disease: a sensational decline in moral standards; a deepening narcissism and corresponding vanishing of altruism; and a mindless revolt against the traditional ethic upon which this country was founded. Drug abuse, which has grown into an enormous industry through the ruthless greed of evil-intentioned individuals, un-

doubtedly poses the most immediate threat of all in terms of physical and mental wellbeing of this country's citizens. But it would be unproductive to wage war against this scourge without simultaneously mounting an assault against the root cause of this and other social disorders. What is the nature of this underlying condition? It is the loss of a sense of purpose, a lack of courage and will, a reluctance to show an independence of spirit, and a failure to derive genuine gratification from the intellectual, aesthetic, and spiritual pursuits of man. A doctor treats symptoms but knows that the disease cannot be licked unless the cause of the symptoms is known; similarly, drug abuse must be fought with all the available resources of government and all sectors of the community, but the underlying condition must be addressed with no less a commitment.

I now come to my final point. In one of our national hymns we find the verse "America, America, G-d shed His grace on thee." It is my firm conviction that much of what ails American society is the diminution of that Divine grace, and the reduction of this lovingkindness, in turn, is a result of a loss of religious faith which until recent times was a universal characteristic of the American people. Fully cognizant of the constitutional limitations which regulate the relations between religion and the state, I nevertheless feel it incumbent to call upon the honorable members of Congress to encourage in every possible legitimate manner a renewal of the vigorous and robust faith which is inherent in the American people.

Mr. WAXMAN. Thank you very much for your testimony.

Let me ask both of you, programs that you are involved in, are the intervention/prevention programs that you are involved in ones that have evolved in the public schools in New York City, or are these programs outside of the public school setting?

Rabbi FRIEDMAN. As I indicated, eight of them are community based, completely unrelated to the school system. Three of them are in the nonpublic school sector. The public school system in New York City has its own prevention education programs, which are funded from a different source. It is the State, but a different agency.

Dr. TURANSKI. I just wanted to specifiy that the Door is not funded as an intervention/prevention program. It is funded from NIDA as a day care drug treatment program. We do prevention and early intervention, but we have to do that free of charge, in a sense. We feel that we must provide these aspects in order to have the comprehensive approach.

We do that either through the use of volunteers, or through the use of students who are in training at The Door.

Mr. WAXMAN. Where do you do your prevention activities?

Dr. TURANSKI. We have a large facility called The Door. It is on 18th Street. It is about 55,000 square feet of space, and within it there are a number of different resources. There are a lot of different services, activities and programs, and many young people come to The Door for many of the services and programs that we provide.

Mr. WAXMAN. I guess what I am thinking of is a program to find young people who have a high potential to become drug abusers. I would think that a person who has that potential is not going to come to such a program until they are ready for treatment.

Dr. TURANSKI. That is right.

Mr. WAXMAN. In the public school and the private school setting, I can see how you might well spot individuals who are having the kinds of problems that could lead to drug abuse.

Dr. TURANSKI. Yes.

Don, do you want to respond to that.

Mr. SHAPIRO. Yes.

I would like to say a couple of things. One, we see about 100 young people a week who are brand new, who are coming to The Door for the first time. Fifty percent of them hear about The Door from friends, community people, agencies, et cetera, and they come voluntarily. Eighteen percent of the 100 or 150 new people a week are people who are abusing drugs, and the others are either not using drugs at all, or maybe in the process of developing some kind of pattern around drug use.

The Door has many entrance points, so we see young people from all over the city. As a matter of fact, 25 percent of the young people that we see come from as far away as Brooklyn, obviously expressing a need to find services.

We really get a sense of the variety of needs that young people express when they come to The Door. They have particular interests, goals, problems, concerns. They don't always come with a specific problem around drug abuse. When they come to The Door, they see The Door as a place for young people. When they come to

The Door, they find out that there is a program that can help them with drugs or alcohol problems, as well as emotional problems, education, et cetera.

We see people who come to The Door who have a drug problem, recognize it and want help. We see people who come, who have a drug problem, but feel their real problem is either the underlying issue of family, school, et cetera, and want help for that, but do not want to deal with the drug issue. Then we see people who do not feel that anything is going on, and we have to nurture a relationship with them before they will let us know more about what is going on.

If I understood your question correctly, we see thousands of young people who don't identify The Door as a drug program, and they can come to it without an image, without a fixed idea, without a fear. At the same time, we see a lot of people who come because they have been told The Door does help with drug problems, and has a treatment program.

Mr. WAXMAN. Do either of you receive NIDA funds?

Rabbi FRIEDMAN. We do not.

Mr. WAXMAN. Does The Door?

Dr. TURANSKI. The Door does as a drug treatment program, not as an intervention program.

Mr. WAXMAN. Rabbi, your program is not a drug treatment program.

Rabbi FRIEDMAN. No.

Mr. WAXMAN. Why do you think NIDA has been resistant in placing any serious emphasis on drug abuse prevention and intervention? Do you have any feelings about that?

The treatment community is well represented, but who speaks for prevention and intervention?

Rabbi FRIEDMAN. I have heard several theories proposed as to NIDA's opposition, and one is that it is simply a convenience. It is easier to fix a matrix for a treatment program than it is for something which is somewhat of an ambiguous nature, such as prevention or intervention.

Another theory is that NIDA is very much research oriented, and it is focusing on the type of activity which can be analyzed in terms of statistical or scientific treatment.

Then it also seems that there might be certain inclinations on the part of the people who head NIDA which lean in different directions.

Mr. WAXMAN. How active are parents in the community and school based prevention and intervention programs?

Rabbi FRIEDMAN. Practically any counseling situation requires, at least at some point, the involvement of parents. One of the directions in which we are moving, in fact my own program in particular, is to bring family counseling as an auxiliary service to deal not only with the youngster, but to deal with the family because experience shows more and more that the problem generally is rooted in the family setting. If you don't deal with the cause, then you are not going to arrive at any permanent solution.

Dr. TURANSKI. I just wondered if I could get back to the question of the lack of a focus on prevention programs by NIDA.

I think that around the time when NIDA was just established as an institute, there was a real scare in regard to drug addicts, and there was a real cry, I think, from the public and from legislators to get the addicts off the streets. I think that in many ways a lot of residential programs were able to get a number of people off the streets, and really out of the public view.

At the same time, there was also that movement toward methadone, where it was seen as an effective, but also a very inexpensive way of dealing with the drug addiction problem.

So, in some ways, I feel that both of those constituencies caught a very substantial share of the amount of moneys that were available. That is at least my opinion.

Mr. WAXMAN. Mayor Koch was here earlier today, and he said that one of the problems, as he sees it, is that there is a failure to monitor drug programs.

As difficult as it would be to monitor drug treatment programs, how difficult would it be to monitor drug prevention and intervention programs?

Rabbi FRIEDMAN. I think that especially since the State has assumed responsibility for the program, the monitoring has improved.

Mr. WAXMAN. This is quite an assumption, because as it was pointed out in discussion this morning, we have Federal money going to States, States giving money to cities, and nobody, according to Mayor Koch, is monitoring as carefully as he thought the programs should be monitored.

Rabbi FRIEDMAN. Our programs have undergone an extensive performance review. Four or five people came down to review the program, and spend 2 or 3 weeks investigating every aspect of the program, which I think is a very thorough way of dealing with the monitoring and evaluation. We did not have this while the city was in control.

I believe my feelings are being echoed by one of my colleagues.

Dr. TURANSKI. One of the great worries is also the evaluation as to whether there is improvement, and whether there has been prevention of drug abuse.

I think that it is going to be difficult. It is difficult to evaluate any of the mental health programs, drug treatment programs, et cetera. I think that you can establish goals for people in terms of areas where they can change their ability to function. There is quite a difference between a person who reads at a grade three reading level, and a person who has gotten their GED and is able to read at a higher level, and is able to get a job.

I think there are very definitive markers that you can look at, and you can measure those. You can see that those things are valuable in helping a person to live a more satisfying and constructive life. I think that those are issues that really have to be looked at as well.

You can also do longitudinal studies with individuals in programs, especially if you start with an adolescent age group. You can hold them over a period of time to see what has been the effect of those programs on their lives, and perhaps compare them with siblings who may not have been involved in programs.

I don't think that it is any more difficult to evaluate a prevention program than it would be to evaluate a treatment program.

Mr. WAXMAN. Congressman Green?

Mr. GREEN. I think that it has been most interesting. I have no questions at this point.

Mr. WAXMAN. Let me thank you very much for your testimony. You have brought us very important information on the various aspects of drug abuse prevention and intervention. It is not only the treatment of one aspect of the problem, but it is the treatment of the whole person.

This concludes the meeting today. I want to thank everyone who has come for being here and for participating.

Without objection the following materials will be included in the hearing record.

[The materials referred to follow:]

NIDA/FMB:

NATIONAL INSTITUTE ON DRUG ABUSE
FUNDS AND TREATMENT SLOTS FOR NEW YORK AND NEW YORK CITY
FISCAL YEAR 1979
(Dollars In Thousands)

	New York State	New York City
Total Program Cost for Treatment Services: 1/		
New York Statewide Services Grant	$35,586	$23,529 2/
Treatment	(32,093)	(21,220)
Administration	(1,325)	(876)
Multi-Outreach Units	(2,168)	(1,433)
Direct Contract-Addiction Research Treatment Center	2,677	2,677
Direct Treatment Grants (HBOs)	6,145	5,481
Total	$44,408	$31,687
Actual NIDA Funds Obligated:		
Treatment Services:		
New York Statewide Services Grant	$21,352	$14,118 2/
Treatment	(19,256)	(12,732)
Administration	(795)	(526)
Multi-Outreach Units	(1,301)	(860)
Direct Contract-Addiction Research Treatment Center	1,607	1,607
Direct Treatment Grants (HBOs)	3,282	2,951
Subtotal Treatment Services	26,241	18,676
Other NIDA Funds:		
Formula Grant	3,012	3,012 3/
Research	6,272	4,340
Training	498	257
Prevention	388	303
Demonstration	842	842
National Drug Abuse Treatment Utilization Survey	349	349
Subtotal Other NIDA Funds	11,361	9,103
TOTAL NIDA FUNDS OBLIGATED	$37,602	$27,779
Funds Awarded for Methadone Maintenance Treatment:		
Total Program Cost	$ 8,655	$ 6,564 4/
Federal Share	$ 5,373	$ 3,938

NIDA Funded Treatment Slots:

Environment	Modality: Detoxification	Methadone Maintenance	Drug Free	Total Slots
New York State				
Inpatient	8	---	---	8
Residential/Detoxification	10	---	---	10
Residential	---	45	2,911	2,956
Day Care	---	297	1,688	1,985
Outpatient	120	4,737	4,404	9,261
Total	138	5,079	9,003	14,220
New York City				
Inpatient	8	---	---	8
Residential/Detoxification	---	---	---	---
Residential	---	45	2,564	2,609
Day Care	---	297	1,483	1,785
Outpatient	120	3,312	1,240	4,672
Total	128	3,654	5,292	9,074

1/ Total program cost for treatment services grants and contracts is the total budgeted amount as approved by NIDA including Federal (NIDA) contributions and match requirements.

2/ Approximately 66 percent of the total New York Statewide Grant (SWSG) funds are used to support treatment services in New York City.

3/ It is assumed that all formula grant funds are used in New York City. States are not required to identify formula grant (Section 409) expenditures by locality, therefore, NIDA is unable to determine the amount of formula grant funds expended in New York City. States are authorized to spend these funds in such areas as treatment and rehabilitation; prevention and education; training; research and evaluation; and administration.

4/ As the Grantee, the New York Single State Agency has allocated approximately $1.6 million in Federal support (NIDA dollars) from the New York Statewide Services Grant to New York City for methadone maintenance treatment services. The remaining funds have been awarded directly to New York City programs through HHO direct treatment grants and one direct contract.

TREATMENT SLOT UTILIZATION

Utilization as of July 31, 1979

DIVISION OF COMMUNITY ASSISTANCE, NIDA

SLOTS AND UTILIZATION

STATE	INPT	DAY CARE	RESIDENTIAL			OUTPATIENT			TOTAL	UTILIZATION	
			DETOX	H.H.	D.F.	DETOX	H.H.	D.F.			%
ALASKA	9	19	1		48	11	212	644	944	959	102
ARIZONA					30	1	22	28	82	69	84
ARKANSAS		10			178	12	865	833	1896	1570	83
CALIFORNIA			18		62	20		448	546	418	77
COLORADO	41	110	32		1852	603	3385	8151	14174	13560	96
CONNECTICUT					99		385	562	1046	924	88
DELAWARE	2	88	15	8	453	25	814	900	2305	2111	92
DIST. OF COL.	2		3		50		104	188	358	331	93
FLORIDA					100	50	430	50	630	592	94
GEORGIA	5	215			749	63	1236	2721	4989	4372	88
HAWAII					128	51	541	740	1460	1552	106
IDAHO		44			92	10	75	158	379	464	122
ILLINOIS								97	97	77	79
INDIANA		73		68	191		1611	905	2848	2668	94
IOWA					37		580	436	1053	874	83
KANSAS					104	1	40	650	795	732	92
KENTUCKY		8					56	81	145	136	94
LOUISIANA					21	1	100	427	549	366	67
MAINE		84	11		114		652	618	1429	1401	98
MARYLAND					11			169	180	197	109
MASSACHUSETTS					78	25	787	340	1156	1165	101
MICHIGAN	7	149			316	60	843	1801	3174	2865	90
MINNESOTA	2	154			193	161	3137	2228	5875	4907	84
MISSISSIPPI		64			68		90	495	717	566	79
MISSOURI					38			73	111	56	50
MONTANA					124	19	580	599	1322	1094	83
NEBRASKA					10			368	378	354	94
NEVADA					26	3	89	133	251	215	86
NEW HAMPSHIRE		25			111	10	90	238	474	422	89
NEW JERSEY					61			255	316	273	86
NEW MEXICO	23	98	10	10	693	205	2132	2718	5849	6144	105
NEW YORK		30			45	32	489	546	1155	1007	87
N. CAROLINA	8	2156	44	45	2884	425	2746	5781	14111	9946	70
N. DAKOTA		27			42	13	149	492	723	727	101
OHIO								80	80	73	91
OKLAHOMA		47	8		182	44	1278	2071	3600	3192	89
OREGON		18			10	30	237	95	380	345	91
PENNSYLVANIA					72		412	515	1099	955	87
RHODE ISLAND	1	134			458	146	2538	2878	6175	5938	96
S. CAROLINA	15	30			105	7	125	542	824	774	94
S. DAKOTA		50			55		60	467	612	648	106
TENNESSEE					15			30	45	44	98
TEXAS	4				67	3	74	373	521	467	90
UTAH		10	10		363	10	1650	3194	5277	4839	92
VERMONT		4	6	16	57	5	166	554	808	738	91
VIRGINIA					20			343	363	295	81
WASHINGTON			1	18	185	9	414	851	1478	1628	110
W. VIRGINIA			2		205	45	433	735	1420	930	65
WISCONSIN								186	266	256	96
WYOMING					88		259	121	968	911	94
GUAM								53	53	42	79
PUERTO RICO		148			208	20	607	20	20	20	100
V. ISLANDS								280	1235	1114	90
AMER. SAMOA											
PACIFIC TRUST TERRITORY											
NATIONAL - - -	123	3761	160	165	11,114	2155	30,484	48,847	96,809	86,420	89
DE FUNDED PROJECTS									344	344	100
NATIONAL---									97,153	86,764	89

July 1979: TREATMENT SLOT UTILIZATION.

STATE		DETOX	H.R.	D.F.	TOTAL
ALABAMA					
	FUNDED SLOTS	21	212	711	944
	UTILIZED SLOTS	25	199	735	959
	PERCENTAGE	119	94	103	102
ALASKA					
	FUNDED SLOTS	2	22	58	82
	UTILIZED SLOTS	2	20	47	69
	PERCENTAGE	100	91	81	84
ARIZONA					
	FUNDED SLOTS	12	863	1021	1896
	UTILIZED SLOTS	10	742	818	1570
	PERCENTAGE	83	86	80	83
ARKANSAS					
	FUNDED SLOTS	36		510	546
	UTILIZED SLOTS	1		417	418
	PERCENTAGE	3		82	77
CALIFORNIA					
	FUNDED SLOTS	676	3395	10113	14174
	UTILIZED SLOTS	669	3501	9390	13560
	PERCENTAGE	99	103	93	96
COLORADO					
	FUNDED SLOTS		385	661	1046
	UTILIZED SLOTS		346	578	924
	PERCENTAGE		90	87	88
CONNECTICUT					
	FUNDED SLOTS	42	849	1414	2305
	UTILIZED SLOTS	55	899	1157	2111
	PERCENTAGE	131	106	82	92
DELAWARE					
	FUNDED SLOTS	4	104	248	356
	UTILIZED SLOTS	1	99	231	331
	PERCENTAGE	25	95	93	93
DIST. OF COL.					
	FUNDED SLOTS	50	430	150	630
	UTILIZED SLOTS	13	494	85	592
	PERCENTAGE	26	115	57	94
FLORIDA					
	FUNDED SLOTS	68	1236	3685	4989
	UTILIZED SLOTS	38	1117	3217	4372
	PERCENTAGE	56	90	87	88
GEORGIA					
	FUNDED SLOTS	51	541	868	1460
	UTILIZED SLOTS	57	491	1004	1552
	PERCENTAGE	112	91	116	106
HAWAII					
	FUNDED SLOTS	10	75	294	379
	UTILIZED SLOTS	10	120	334	464
	PERCENTAGE	100	160	114	122
IDAHO					
	FUNDED SLOTS			97	97
	UTILIZED SLOTS			77	77
	PERCENTAGE			79	79
ILLINOIS					
	FUNDED SLOTS		1709	1139	2848
	UTILIZED SLOTS		1581	1087	2668
	PERCENTAGE		93	95	94
INDIANA					
	FUNDED SLOTS		580	473	1053
	UTILIZED SLOTS		467	407	874
	PERCENTAGE		81	86	83
IOWA					
	FUNDED SLOTS	1	40	754	795
	UTILIZED SLOTS	0	26	713	739
	PERCENTAGE	0	65	95	93
KANSAS					
	FUNDED SLOTS		56	89	145
	UTILIZED SLOTS		49	87	136
	PERCENTAGE		88	98	94
KENTUCKY					
	FUNDED SLOTS	1	100	448	549
	UTILIZED SLOTS	1	90	275	366
	PERCENTAGE	100	90	61	67
LOUISIANA					
	FUNDED SLOTS	11	671	817	1499
	UTILIZED SLOTS	13	724	754	1491
	PERCENTAGE	118	108	92	99

STATE		DETOX	M.H.	D.F.	TOTAL
MAINE					
	FUNDED SLOTS			180	180
	UTILIZED SLOTS			197	197
	PERCENTAGE			109	109
MARYLAND					
	FUNDED SLOTS	25	707	424	1156
	UTILIZED SLOTS	56	742	367	1165
	PERCENTAGE	224	105	87	101
MASSACHUSETTS					
	FUNDED SLOTS	67	843	2264	3174
	UTILIZED SLOTS	81	757	2027	2865
	PERCENTAGE	121	90	90	90
MICHIGAN					
	FUNDED SLOTS	163	2137	2575	5875
	UTILIZED SLOTS	158	2643	2106	4907
	PERCENTAGE	97	84	82	84
MINNESOTA					
	FUNDED SLOTS		90	627	717
	UTILIZED SLOTS		81	485	566
	PERCENTAGE		90	77	79
MISSISSIPPI					
	FUNDED SLOTS			111	111
	UTILIZED SLOTS			56	56
	PERCENTAGE			50	50
MISSOURI					
	FUNDED SLOTS	19	580	723	1322
	UTILIZED SLOTS	30	459	605	1094
	PERCENTAGE	158	79	84	83
MONTANA					
	FUNDED SLOTS			370	370
	UTILIZED SLOTS			354	354
	PERCENTAGE			94	94
NEBRASKA					
	FUNDED SLOTS	3	89	159	251
	UTILIZED SLOTS	2	71	142	215
	PERCENTAGE	67	80	89	86
NEVADA					
	FUNDED SLOTS	10	90	374	474
	UTILIZED SLOTS	5	69	348	422
	PERCENTAGE	50	77	93	89
NEW HAMPSHIRE					
	FUNDED SLOTS			316	316
	UTILIZED SLOTS			273	273
	PERCENTAGE			86	86
NEW JERSEY					
	FUNDED SLOTS	238	2142	3469	5849
	UTILIZED SLOTS	538	2236	3370	6144
	PERCENTAGE	226	104	97	105
NEW MEXICO					
	FUNDED SLOTS	52	482	621	1155
	UTILIZED SLOTS	6	327	674	1007
	PERCENTAGE	12	68	109	87
NEW YORK					
	FUNDED SLOTS	504	3108	10499	14111
	UTILIZED SLOTS	432	2981	6533	9946
	PERCENTAGE	86	96	62	70
N. CAROLINA					
	FUNDED SLOTS	15	164	544	723
	UTILIZED SLOTS	27	178	522	727
	PERCENTAGE	180	109	96	101
N. DAKOTA					
	FUNDED SLOTS			80	80
	UTILIZED SLOTS			73	73
	PERCENTAGE			91	91
OHIO					
	FUNDED SLOTS	72	1[illegible]8	2250	3600
	UTILIZED SLOTS	61	9[illegible]2	2159	3192
	PERCENTAGE	85	76	96	89
OKLAHOMA					
	FUNDED SLOTS	30	237	113	380
	UTILIZED SLOTS	4	243	92	345
	PERCENTAGE	13	105	81	91

STATE		DETOX	N.M.	D.F.	TOTAL
OREGON					
	FUNDED SLOTS	0	412	687	1099
	UTILIZED SLOTS	4	337	614	955
	PERCENTAGE	0	82	89	87
PENNSYLVANIA					
	FUNDED SLOTS	145	2538	3492	6175
	UTILIZED SLOTS	237	2387	3314	5938
	PERCENTAGE	163	94	95	96
RHODE ISLAND					
	FUNDED SLOTS	22	125	677	824
	UTILIZED SLOTS	10	124	640	774
	PERCENTAGE	45	99	95	94
S. CAROLINA					
	FUNDED SLOTS		60	552	612
	UTILIZED SLOTS		78	570	648
	PERCENTAGE		130	103	106
S. DAKOTA					
	FUNDED SLOTS			45	45
	UTILIZED SLOTS			44	44
	PERCENTAGE			98	98
TENNESSEE					
	FUNDED SLOTS	7	74	440	521
	UTILIZED SLOTS	3	69	395	467
	PERCENTAGE	43	93	90	90
TEXAS					
	FUNDED SLOTS	20	1690	3567	5277
	UTILIZED SLOTS	19	1489.	3331	4839
	PERCENTAGE	95	88	93	92
UTAH					
	FUNDED SLOTS	11	182	615	808
	UTILIZED SLOTS	13	143	582	738
	PERCENTAGE	118	79	95	91
VERMONT					
	FUNDED SLOTS			363	363
	UTILIZED SLOTS			295	295
	PERCENTAGE			81	81
VIRGINIA					
	FUNDED SLOTS	10	432	1036	1478
	UTILIZED SLOTS	10	430	1188	1628
	PERCENTAGE	100	100	115	110
WASHINGTON					
	FUNDED SLOTS	47	433	940	1420
	UTILIZED SLOTS	67	320	543	930
	PERCENTAGE	142	74	58	65
W. VIRGINIA					
	FUNDED SLOTS			266	266
	UTILIZED SLOTS			256	256
	PERCENTAGE			96	96
WISCONSIN					
	FUNDED SLOTS		259	709	968
	UTILIZED SLOTS		261	650	911
	PERCENTAGE		101	92	94
WYOMING					
	FUNDED SLOTS			53	53
	UTILIZED SLOTS			42	42
	PERCENTAGE			79	79
GUAM					
	FUNDED SLOTS		20		20
	UTILIZED SLOTS		20		20
	PERCENTAGE		100		100
PUERTO RICO					
	FUNDED SLOTS	20	607	608	1235
	UTILIZED SLOTS	18	547	549	1114
	PERCENTAGE	90	90	90	90
V. ISLANDS					
	FUNDED SLOTS				
	UTILIZED SLOTS				
	PERCENTAGE				
AMER. SAMOA					
	FUNDED SLOTS				
	UTILIZED SLOTS				
	PERCENTAGE				

STATE		DETOX	H.M.	D.F.	TOTAL
PACIFIC TRUST TERRITORY	FUNDED SLOTS	2,465	31,037	63,307	96,809
	UTILIZED SLOTS	2,676	28,935	54,809	86,420
	PERCENTAGE	109	93	87	89
NATIONAL--- (Not incl. DR funded projects)	FUNDED SLOTS				344
	UTILIZED SLOTS				344
	PERCENTAGE				100
DR FUNDED PROJECTS	FUNDED SLOTS				97,153
	UTILIZED SLOTS				86,764
	PERCENTAGE				89
NATIONAL---	FUNDED SLOTS				
	UTILIZED SLOTS				
	PERCENTAGE				

As of July 31, 1979

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES DIVISION

March 13, 1979

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Interstate and
Foreign Commerce
House of Representatives

Dear Mr. Chairman:

In view of your office's interest in our work concerning drug abuse treatment efforts of the National Institute on Drug Abuse, enclosed for your information is a copy of our March 2, 1979, statement before the Subcommittee on Alcoholism and Drug Abuse, Senate Committee on Human Resources.

Sincerely yours,

Gregory J. Ahart
Director

Enclosure

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:00 a.m. EST
Friday, March 2, 1979

STATEMENT OF
GREGORY J. AHART, DIRECTOR
HUMAN RESOURCES DIVISION
BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM & DRUG ABUSE
COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE
ON
DRUG ABUSE TREATMENT EFFORTS
OF THE NATIONAL INSTITUTE ON DRUG ABUSE

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear here today to discuss our ongoing review of drug abuse treatment efforts of the National Institute on Drug Abuse (NIDA). We started this review as a follow-on to earlier work in which we had identified several weaknesses in the operations of NIDA and its grantees and contractors. NIDA was aware of many of these problems and had initiated corrective actions. Our current review, directed at assessing NIDA's progress in solving its problems, was begun about 1 year after NIDA started its corrective actions.

In June 1978, shortly after we started our review, the Subcommittee asked us to provide it with the results of our work in time for these hearings.

Because our review is not yet complete the observations we are presenting must be considered as tentative. We have not fully developed the causes of the deficiencies noted nor have we developed recommendations for correcting them.

Our work to date shows that a number of the problems that we and others had identified continue to exist. Specifically, we found that

--NIDA's method of funding drug abuse treatment programs contributes to problems such as (1) unused capacity in treatment programs, (2) inflation of reported treatment utilization rates, (3) low levels of treatment provided to some abusers, and (4) funding

levels that do not reflect actual costs of treatment.

--NIDA's standards for controlling the design and operation of treatment programs should be clarified and upgraded.

--NIDA's plans for States to establish standards that are equivalent to or more stringent than the Federal funding criteria have moved very slowly.

INTRODUCTION

Drug abuse in the United States costs an estimated $17 billion a year. Estimates of the number of drug abusers are difficult to obtain. However, a recent Office of Drug Abuse Policy publication shows that in 1977 an estimated 1.8 million persons used amphetamines for nonmedical purposes, 1.7 million used cocaine, 550,000 used heroin, 4.6 million used depressants and sedatives other than alcohol, 1.1 million used psychedelic drugs, and 175,000 used inhalants.

Each year almost 1 million people are treated for drug abuse problems in the United States. In fiscal year 1978, an estimated $518 million was spent for these drug abuse treatment services of which NIDA provided $132 million, the States provided $164 million and the remainder was provided by such sources as the Veterans Administration, local governments, and the private sector.

NIDA, under the authority of Section 410 of Public Law 92-255, administers a comprehensive program of drug abuse treatment services throughout the United States primarily through two mechanisms

--a statewide services contract which is a cost reimbursement/cost sharing arrangement with a designated State agency. Under this mechanism, State agencies subcontract with local drug treatment programs to provide the treatment services.

--a direct grant to or contract with a local drug treatment program. Under this mechanism, NIDA deals directly with the program with little or no State involvement.

In addition to the above, the States may use formula

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funds provided under Section 409 of Public Law 92-255 to fund treatment services.

The NIDA funded treatment services are provided in four environments--outpatient, residential, day care, and inpatient. Over 83 percent of the services are provided in an outpatient environment. The drug abusers are treated in either a drug free, methadone maintenance, or detoxification modality. Of these, over 61 percent of the abusers are in drug free programs and over 35 percent are in methadone maintenance.

CONCERNS WITH NIDA'S METHOD OF PROVIDING FUNDS

We have several observations concerning NIDA's method of funding the treatment of drug abuse:

--based on reported utilization of treatment capacity, the nationwide treatment program could serve more drug abusers,

--because reported utilization rates are inflated, there is even more potential for treating additional drug abusers,

--the low level of success in rehabilitating drug abusers may in part be due to the low level of treatment provided, and

--NIDA cost ceilings may discourage programs from providing necessary treatment to their drug abusing clients.

As we mentioned, NIDA contracts with States and with individual programs to provide treatment services to drug abusers. Over 70 percent of the treatment funds is allocated to States, with the remainder going directly to individual programs. NIDA's management expects to fund virtually all of its assistance through statewide services contracts by fiscal year 1980.

NIDA funds are provided through a slot funding concept. Under this slot funding mechanism NIDA funds treatment services based on the number of abusers in a program who could be in treatment at any particular time under conditions of full operation. Full operation, or capacity, is expressed

in terms of slots; one slot can be defined as the capability to treat the equivalent of one abuser for a 12-month period. At any point in time, a program may be treating more or less abusers than its number of slots.

NIDA uses the concept of guideline slot cost ceilings as the basis for funding drug abuse treatment programs. Guideline ceilings represent the maximum amount against which NIDA will fund part of treatment costs. Based on criteria in the legislation, NIDA's share can range from 90 percent to 60 percent. Established ceilings for fiscal year 1979 range from $40,000 for an inpatient slot down to $1,940 for an outpatient slot.

Thus a State or a provider with, for example, a contract to provide 100 slots of outpatient drug-free treatment will have a ceiling of $194,000 for a year. The State or provider prepares a budget showing the estimated costs of personnel, facilities, utilities, and other items. If the budget does not exceed $194,000, NIDA will fund at least 60 percent of the budget. NIDA will not participate in any of the costs exceeding $194,000.

NIDA believes that the treatment slot concept is a simple, flexible, easy-to-monitor approach to funding a nationwide treatment system. However, there are several problems which result from the use of slot funding. These problems lead us to tentatively conclude that NIDA needs to develop and implement a funding mechanism that will provide greater assurance that Federal funds are expended in the most effective and efficient manner. Until another funding mechanism is adopted by NIDA, we believe the following factors need immediate attention.

Unused capacity in treatment programs

The NIDA assisted drug abuse program could serve more drug abusers without any significant increase in costs because treatment capacity is underutilized.

The nationwide utilization rate, as reported by NIDA, declined from 95 percent in October 1975 to 89 percent in October 1978. NIDA does not want the States and treatment providers to fall below an 85 percent slot utilization rate. We noted three States with a pattern of reported utilization

rates of about 80 percent.

By comparison, seven States reported utilization rates of more than 100 percent in October 1978. For example, providers in one State reported that they gave outpatient drug-free treatment to 272 drug abusers, although it is funded for only 226 slots--a utilization rate of 120 percent.

It has been noted by authorities that the slot funding mechanism does not provide an incentive for a provider or a State to raise their slot utilization rate. There is no incentive for a program to increase its utilization rate because NIDA customarily pays its full share of slot costs regardless of a program's utilization rate.

The reported utilization rates indicate that more drug abusers could be treated. For example, increasing the utilization rate from its 1978 national average of 89 percent to its 1975 rate of 95 percent, would involve treatment of approximately 12,000 more drug abusers annually. The estimate of 12,000 is computed on the basis that NIDA funds about 100,000 slots annually and that the average treatment period is 6 months.

Since (1) some providers and States have apparently developed techniques to raise their rates above 100 percent, and (2) other providers in States had inflated their reported utilization rates, as discussed later, we believe there is potential for NIDA to increase the national rate.

Reported utilization rates are inflated

Numerous attempts have been made to validate the reported rates of utilization of the slots. The results of these reviews indicate that the utilization rates are inflated. Thousands of abusers are being reported as served who are not being served.

NIDA requires that each treatment provider have face-to-face contact every thirty days with the abuser. If such contact is not made, the provider may not count that abuser as an "active client." While the issue of frequency of contacts with abusers will be discussed later, we want to point out that the unused capacity problem

discussed above is made worse by the problem of an inflation of reported utilization rates.

A management consultant firm, under contract with NIDA continually reports that utilization rates are overstated. For example, in one of the States with a large share of NIDA's assistance, the reported rate was 84 percent but the actual rate was 74 percent. Within the past month, the report on tests in another State showed that the actual rate was 79 percent, but the reported rate was 98 percent.

We believe these examples are a fair presentation of the results of the tests made by the management consultant. While the firm does not go to every provider in a State, it verifies the reported utilization for a given provider using a scientific sample.

An ongoing audit by HEW's Inspector General, showed that one clinic reported a utilization rate of 109 percent and another clinic reported a rate of 87 percent; the actual rates were 76 percent and 56 percent, respectively.

Because of the attention given to this issue by the management consultant and the HEW Inspector General, our work was very limited. Yet we also found instances of inflated utilization rates.

We are cognizant of several steps taken by NIDA to upgrade the quality of the reported data. Some of these corrective actions were outlined to us in April 1978. Yet, the problem remains.

Though we have not completed our review, we have tentatively concluded that the providers could be treating many more drug abusers since the actual utilization rate is so much lower, in many States, than the reported rate. While none of the reviews allow projections of the results on a nationwide basis, the differences found are substantial. To illustrate, if the actual nationwide rate was 5 percent less than the reported rate, providers have the capacity to treat about 10,000 more drug abusers annually, since each percentage point represents the treatment of about 2,000 abusers.

<u>Low level of treatment provided to abusers</u>

Concern has been expressed by NIDA and others at the

lack of treatment given to abusers by providers; yet the problem is not resolved. Since the reported rate of completing treatment is about 20 percent, the low level of treatment provided to the abusers may well be one of the causal factors of the low success rate. The slot funding mechanism does not provide incentives to a program to increase the level of services provided to abusers because a program will receive the same level of NIDA funding for an abuser seen once per month as for an abuser seen 10 times per month.

According to NIDA's policy it is the responsibility of the State and the provider to make the clinical judgment of how often a drug abuser will be counseled and the kind of services to be provided. However, for purposes of continuing to receive funding, a provider is required by NIDA to have a face-to-face contact with the abuser at least once a month.

In December 1977, NIDA informed program directors that its work showed that the number of monthly contacts were low. NIDA explained that its findings were compatible with similar findings of its management consultant. The consultant had reported that the concept of funding programs on the basis of treatment slots does not appear to provide incentives that encourage a high level of client contact.

The HEW Inspector General's review has shown that clients in the five programs tested received, on the average, less than 30 minutes a week of counseling. The average weekly counseling of the drug abuser ranged from 10 minutes to 45 minutes. In this regard, NIDA's funding criteria, with which all programs must abide, states that a minimum of 3 hours of formalized counseling per week shall be made available for each patient in outpatient methadone and drug-free programs. As discussed later, this requirement is vague and unenforceable.

The low level of contact continues to be brought to the attention of the States and NIDA by the management consulting firm. For example, in reports recently issued, the firm found that in one State about 75 percent of the abusers in treatment had two or less contacts per month; in a second State, 49 percent of the clients were seen on two or less

occasions per month.

We recognize that the frequency and duration of client contacts will vary. For example, some authorities say that there are circumstances when an outpatient drug abuse client in the final stages of treatment may need only one contact per month. Further, a heroin abuser coming in for only methadone may not require any counseling.

A member of HEW's National Advisory Council on Drug Abuse, who is also a treatment provider, explained that counseling of heroin abusers in an outpatient drug-free program could range from hourly sessions three to five times a week for the abuser with major family and social problems, to once a week or less for an abuser about to complete treatment. He further stated that in practice, however, the tendency has been to regress to the most minimal contact so that the national average is only two to three times a month.

The management consulting firm has provided reasons for low levels of contact:

--There are problems in motivating drug abusers who are required by the courts to be treated.

--Programs receive the same level of funding regardless of the number of times an abuser is seen each month.

In our discussions with the director of a State drug abuse agency, who is also a past president of the National Association of State Alcohol and Drug Abuse Directors, we were advised that current clinical judgment is that once-a-month contact is inadequate for counseling purposes.

Based on the evidence we have gathered to date, it appears that NIDA needs to upgrade its funding criteria to increase the level of contact with the drug abuser.

Slot cost ceilings not consistent with actual costs

Since the slot concept provides for cost reimbursement based on a cost ceiling rather than on the actual cost of treatment, the ceilings may prevent programs from providing the necessary treatment services to drug abusers.

A technical assistance contractor reported in May 1978, that the actual cost of treating an individual may have little relationship to the budgeted slot cost. According to

NIDA officials, the cost ceilings were established in 1973 based on the opinions of several experts, rather than on on historical cost data. They recognize that the slot ceilings are significantly lower than the actual cost incurred by the treatment programs. They further explained that as long as they have to operate the drug abuse treatment program under restrictions of a static budget and treatment capacity, they do not plan to change the funding mechanism, nor can they raise the cost ceiling to a realistic level.

Officials in the States we visited--California, New York, and Illinois--believe treatment costs are higher than the ceilings. A study completed by the California Division of Drug Abuse in March 1978, showed that the estimated cost for residential programs in California was about $12,000 annually per client; NIDA's slot cost ceiling was $5,400.

Further, the slot cost ceilings do not recognize other factors such as:

--differences in salaries of clinical personnel among different parts of the country; and

--differences in the cost of drug-free treatment versus treating a person with methadone.

For example, Federal regulations require that projects dispensing methadone be staffed with a minimum of one physician and two nurses. According to the chief of planning for the Los Angeles Drug Abuse Office, these staffing requirements lead to higher personnel costs in methadone maintenance programs than in drug-free programs. Yet both types of treatment are governed by the same guideline cost ceiling.

Some of NIDA's current work will provide information on the actual cost of treating drug abusers.

NIDA IS EXPLORING DIFFERENT TYPES OF FUNDING MECHANISMS

NIDA is exploring alternative ways to fund the Federal Government's share of the cost of drug abuse treatment.

The slot funding mechanism is considered by NIDA to be unique in the Federal Government. We recognize the utility of such a mechanism in the 1974-1975 period when NIDA needed to rapidly expand the national treatment system in response

to public concerns over the increasing level of heroin abuse. However, as discussed earlier, there are several problems which result from the use of slot funding.

In a September 1978 publication, the National Association of State Alcohol and Drug Abuse Directors stated regarding slot funding that

--only very imprecise cost information is available on which to base financial management decisions,

--it is difficult to clearly state what treatment services are being provided to whom at any given time, or over a period of time,

--there is no precise mechanism to ensure service delivery accountability, and

--slot funding may permit or encourage minimum contacts with a client and loose standards for client care.

Whether to continue using this funding mechanism has been a question before NIDA for some time. For example:

--we discussed the issue with NIDA officials in the summer of 1977.

--NIDA's management consulting firm addressed the concerns about slot funding in their January 1978 report.

--the White House's Office of Drug Abuse Policy in a March 1978 report, recommended the evaluation of a new funding mechanism and its adoption, if feasible.

--the panel on psychoactive drug use of the President's Commission on Mental Health concluded that a fundamental reappraisal of the quality of drug treatment services is necessary in part because of its concern that the quality of treatment is being neglected under NIDA's slot funding concept.

NIDA has approached the growing concerns with a number of exploratory programs. One of NIDA's goals in fiscal year 1978, was to develop a methodology to reimburse costs in a manner which is closely related to the quality and quantity of patient care units of service actually being provided. NIDA plans in fiscal year 1979, to examine possible variations of the existing treatment slot system

and other possible funding systems, including unit costing.

Several States use the unit of service concept. Under this mechanism, programs are reimbursed for the actual cost of service provided to the drug abuser. The advantages claimed are:

--overcoming clinical and financial management problems of accountability; and

--meeting third party reimbursement requirements to assist the treatment provider in obtaining such reimbursements.

However, some negative features of the unit of cost concept identified are

--increased paperwork;

--increased cost of monitoring; and

--possible funding instability for some programs.

We have tentatively concluded that the slot funding concept does not provide incentives for a program to

--increase its utilization rate because NIDA customarily pays its full share of slot costs regardless of a program's utilization rate, and

--increase the level of services provided to abusers because a program will receive the same level of NIDA funding regardless of the frequency or duration of treatment services provided to an abuser.

While we have not reached a judgment that unit of service funding is the best of the alternatives being explored, NIDA needs to develop and implement a mechanism that will provide greater assurance that Federal funds have been expended in the most effective and efficient manner.

CONCERNS WITH DRUG ABUSE TREATMENT STANDARDS

During 1973 the Special Action Office for Drug Abuse Prevention (SAODAP) took two major initiatives which signaled the beginning of Federal involvement in the development of drug abuse treatment standards. These initiatives were considered necessary because (1) SAODAP was concerned about the quality of service being provided to drug abusers, (2) traditional health care providers had not responded to

drug abusers' needs and, therefore, drug abuse treatment was being provided by ex-addicts and other non-professionals, and (3) the Federal Government needed a system which would control how its treatment funds were being spent.

The first of these initiatives was the development of a set of treatment standards known as the Federal funding criteria. The funding criteria were developed as minimal standards of acceptable treatment which must be met in order to receive Federal funds. The promulgation of "minimal" standards was necessary so that there would be the least possible disruption to the drug abuse treatment field. It was believed that, had more stringent standards been imposed, much of the then existing drug abuse treatment system would have been unable to continue operations. The funding criteria represent, according to NIDA, established levels of program performance achievable by all drug treatment programs with minimal assistance from the Federal Government. NIDA believed the criteria would provide the system needed to control how Federal funds were spent and would provide guidance to the nonprofessionals staffing many of the federally funded treatment programs. NIDA continues to incorporate the funding criteria into its drug abuse treatment grants and contracts and they remain as the minimal operating criteria for NIDA-funded treatment programs.

The second SAODAP initiative regarding standards was the awarding of a grant to the Joint Commission on Accreditation of Hospitals to develop standards for the voluntary accreditation of drug abuse treatment facilities. In contrast to the minimal requirements of the Federal funding criteria these standards were expected to represent maximally achievable standards for the drug abuse treatment field. SAODAP believed that Joint Commission accreditation would help assure quality treatment for drug abusers and would increase the probability of third party reimbursement for drug abuse treatment services. The SAODAP grant was replaced by a NIDA contract in June 1975 and the Joint Commission published its standards in the latter part of 1975. Since then the standards have been field-tested and revised where

necessary, and a system of weights has been developed to prioritize the elements included in the accreditation process. The total Federal cost to develop these standards was about $659,000.

At the same time that the Federal funding criteria and the Joint Commission treatment standards were being developed, the States were acting to develop their own systems for licensing and/or certifying drug abuse treatment programs. This action was mandated by Public Law 92-255 which required the States to develop and implement licensing or accreditation procedures. However, in 1974 Public Law 94-63 repealed this requirement and State certification systems were no longer mandatory. NIDA continues to encourage and assist the States to develop treatment standards. It is NIDA's hope that, despite the repeal of the State licensing requirement, States will continue to move toward the adoption of licensing or certification requirements. To this end, NIDA has told State authorities that if State promulgated standards are substantially consistent with the Federal funding criteria, NIDA will accept them in lieu of the criteria. NIDA hopes that the standards developed by the States will be more stringent than the criteria, thus upgrading the quality of treatment provided in the States.

COMPARISON OF FEDERAL FUNDING CRITERIA AND JOINT COMMISSION TREATMENT STANDARDS

In reviewing the treatment standards contained in NIDA's funding criteria, we noted that:

--some standards are vague and, therefore, cause problems of enforcement and interpretation, and

--important aspects of the quality of treatment are not addressed by the standards.

Therefore, we believe that the treatment standards of the funding criteria should be clarified and upgraded.

Our audit work at NIDA includes an examination of selected elements of the funding criteria and Joint Commission standards. Although our efforts are not intended to directly address the issue of quality of care, we have been guided by an awareness of the importance of this issue. We recognize

that the funding criteria were never intended to ensure that quality services would be delivered. However, these standards of performance were expected to ensure that a program's design and operation have been established within a framework such that quality treatment services can be delivered.

It is within this context that we examined portions of the funding criteria. We identified elements of these standards which are so vaguely written that they are unenforceable and/or do not provide sufficient detail to ensure uniform interpretation. This vagueness is illustrated by the funding criteria requirement for counseling services. NIDA-funded outpatient treatment programs are required to "make available" a minimum of 3 hours of formalized counseling per week for each client. Similarly, residential and day care programs are required to "make available" 10 hours of formalized counseling per week for each client. NIDA personnel responsible for monitoring program compliance were unable to define what the phrase "make available" means and agreed that the requirement is unenforceable.

Another example of a vague funding criteria requirement is that which deals with client records. The funding criteria require only that a client record system be established which documents and monitors client care, is kept confidential and complies with all Federal and State reporting requirements. Inadequate client record systems have been continually identified as serious problems by NIDA's management consultants. Improvement in the quality of client record systems could be achieved if the funding criteria were more specific.

We are also concerned whether the funding criteria are still appropriate as minimal standards of performance for current drug abuse treatment programs and as a mechanism to control their design and operation. In order to make some assessment of the adequacy of the funding criteria, we compared selected Joint Commission requirements with the funding criteria. The Joint Commission elements selected for comparison are those we judged to be related to quality of care. Our judgment was influenced by discussions with NIDA personnel and other experts in drug abuse

treatment. Our purpose was to determine the extent to which these "quality of care" elements of the Joint Commission standards were addressed by the funding criteria. Our comparison included four main topics: program administration, personnel, intake and assessment procedures, and community linkages. In the interest of time we will just discuss program administration.

We included program administration elements in our comparison because we were told by experts that such elements contributed to a stable and well-run program and that such a program was more likely to provide quality care.

In general, the funding criteria do not address program administration elements. In contrast, the Joint Commission standards include a variety of requirements regarding program structure and operation.

More specifically, the Joint Commission standards require that programs have a governing body that has ultimate authority for the program working through an appointed executive director responsible for the overall operation of the program. The funding criteria do not have requirements for program structure.

The Joint Commission requires written policies and procedures for many program areas including fiscal management, staffing, facilities management, and client records. The funding criteria do not.

The Joint Commission requires programs to do continuous and comprehensive evaluation, using explicit and measurable criteria. The funding criteria do not require internal program evaluation.

The Joint Commission requires that there be written policies and procedures that establish a staff development program and that designate an individual to supervise staff development activities. Staff development must include orientation for entry-level staff, on-the-job training, in-service education, and opportunities for continuing job-related education. Similarily, the Joint Commission standards require written policies for recruitment, selection,

promotion and termination of program staff members. They also require written job descriptions for all positions. The funding criteria do not address the need for staff development or for personnel policies.

The Joint Commission standards we reviewed are considerably more specific and detailed than the funding criteria, and in many cases address issues that are not addressed in the criteria. The Joint Commission standards appear to offer considerably more guidance to drug abuse treatment programs. Although we recognize that the funding criteria and the Joint Commission standards were developed for different purposes, we are concerned about the significant differences in content and specificity between the two sets of standards, especially in those areas identified as important to the delivery of quality drug abuse treatment services. Therefore, we believe that the funding criteria should be clarified and upgraded.

NIDA's current efforts

Several actions undertaken by NIDA during the period that we have been reviewing NIDA's programs have impacted on the treatment standards issue.

The first of these actions is the revision of the contractual requirements contained in NIDA's statewide service contracts. The revised contractual language includes more stringent and/or explicit requirements for program staff training, community linkages, program evaluation and client records. These changes should, in our opinion, assist in upgrading the treatment services provided to drug abusers.

Secondly, in a February 1979 letter to program directors, NIDA strongly encouraged providers to seek Joint Commission accreditation. Although NIDA has, in the past, cooperated with the Joint Commission in developing standards and encouraged programs to seek accreditation, this latest action provides stronger endorsement of the accreditation process. Additionally, NIDA has made it clear to program administrators that the cost of the accreditation process is a reimbursable cost under NIDA grants and contracts. Finally, NIDA has agreed to accept Joint Commission accredi-

tation in lieu of the Federal funding criteria in determining eligibility for continued Federal funding. Currently, there are 23 clinics in 17 NIDA-funded drug abuse treatment programs which have received Joint Commission accreditation.

A third activity undertaken by NIDA is encouraging State development of licensure procedures for drug abuse treatment programs. As we have mentioned, NIDA efforts in this area have been ongoing for several years. NIDA has provided technical assistance and consultation to interested States and has reviewed those State standards submitted to it for conformity with the funding criteria. To date, 26 States have submitted licensure standards to NIDA for review. However, only five of these have been approved by NIDA and accepted in lieu of the funding criteria. In spite of NIDA's efforts to encourage States to develop their own standards, little progress has been realized in this area. Only one State has had its standards approved since 1976.

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Mr. Chairman, this concludes my statement. We shall be happy to answer any questions that you or other members of the Subcommittee might have.

DAWN: EMERGENCY Room REPORTS

DRUG ABUSE WARNING NETWORK SPECIAL REGIONAL REPORT SERIES

REPORTS BY THE INFORMATION RESOURCES UNIT, INFORMATION SYSTEMS SECTION, OFFICE OF COMPLIANCE AND REGULATORY AFFAIRS, DRUG ENFORCEMENT ADMINISTRATION (TELEPHONE (202) 633-1316)

NEW YORK STATE

SMSA NAME: NEW YORK

TABLE A - CONSISTENTLY REPORTING EMERGENCY ROOMS

CSA SCHED	NAME,	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
1	HEROIN	102	105	105	90	111	96	100	106	109	114	113	100	172	166	1,493
1	[illegible]	16	17	19	20	22	17	24	22	22	19	17	23	22	21	225
1	LSD	16	17	19	20	22	17	24	22	22	19	17	23	22	21	225
1	MESCALINE	3	2	1	4	1	2	2	4	2	4	2	2	1	0	30
1	MESCALINE	2	3	1	1	0	1	0	1	1	2	2	4	1	3	22
1	MISC & UNKNOWN HALLU	0	1	1	0	0	1	0	0	2	0	4	3	0	0	12
1	ACID MOCD MORE SEEDS	1	0	0	0	0	2	0	1	0	0	0	0	0	0	4
1	SPEEDBALL	0	0	0	1	0	0	0	0	1	0	0	0	1	0	3
1	DMT	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
SUB-TOTAL FOR: CSA1		220	244	196	216	223	232	220	236	210	240	229	247	215	217	3,493
2	METHADONE	163	179	137	111	142	145	113	142	130	165	157	142	136	131	1,888
2	DILAUDID/DIHYDRA	91	102	75	81	94	83	81	84	83	94	86	110	96	80	1,180
2	PCP	79	114	83	83	67	72	79	91	140	86	88	97	116	81	1,086
2	COCAINE	53	68	57	66	76	89	89	72	73	69	80	86	75	57	940
2	AMPHETAMINE	33	18	14	21	34	14	32	35	51	46	46	88	63	73	551
2	SECORABARBITAL	46	32	20	19	33	36	29	31	24	32	29	33	26	13	376
2	METHAQUALONE	17	19	18	24	21	19	38	33	36	26	24	41	34	36	370
2	BARBITURATE SEDATIVE	39	25	26	14	29	25	21	24	28	42	31	32	34	22	373
2	DOPERIDO	12	7	1	11	9	0	0	11	23	18	11	17	17	17	177
2	[illegible]	0	0	0	0	17	13	13	0	0	0	0	0	0	0	43
2	SLEEPING PILL	10	10	4	10	7	0	3	0	10	11	5	6	3	6	104
2	CODEINE	1	4	0	7	1	0	0	4	6	7	7	12	13	9	100
2	MEPERIDINE HCL	4	3	1	0	0	4	0	14	3	6	11	4	7	6	68
2	PENTOBARBITAL	3	4	3	9	6	7	7	3	3	2	8	7	6	8	70
2	SPEED	3	7	7	3	0	4	3	8	4	11	4	4	4	4	64
2	NARCOTIC ANALGESICS	2	4	1	3	0	1	1	3	1	7	4	8	9	3	49
2	HYDROMORPHONE	1	3	4	1	3	4	2	2	3	2	0	3	3	1	33
2	MORPHINE	0	0	1	1	2	1	0	4	1	2	1	1	1	1	16
2	AMOBARBITAL	1	0	1	0	0	7	0	0	0	2	0	3	1	0	15
2	METHYLPHENIDATE	1	3	2	2	0	1	0	0	0	2	0	1	2	0	14
2	DEXTROAMPHETAMINE	0	2	0	2	0	0	2	1	1	1	1	1	0	1	14
2	SYNTHETIC NARCOTIC	0	0	0	0	0	0	0	0	1	2	1	0	0	0	10
2	BAMB BLACK BEAUTIES	1	0	0	0	1	0	0	1	0	1	0	0	0	1	7
SUB-TOTAL FOR: CSA2		532	648	477	464	477	472	511	604	562	590	536	702	719	574	7,900
3	BUTALBITAL COMBS	11	7	8	9	4	10	17	1	4	4	9	10	11	9	116
3	ACETAMINOPHEN W CODE	9	8	6	10	6	7	11	11	3	7	7	10	7	6	113
3	GLUTETHIMIDE	3	2	0	3	3	1	4	4	1	0	4	4	3	3	42
3	METHYPRYLON	0	0	4	4	4	4	4	4	0	0	3	0	2	3	38
3	APC W CODEINE	2	4	0	0	3	3	1	0	0	4	2	0	0	0	16

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCE ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES IT INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST 90% OF THE DAYS INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

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NEW YORK STATE

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3	BUTABARBITAL	1	2	0	0	0	1	0	2	0	0	1	2	0	1	10
3	HYCODAN	1	1	0	2	0	1	0	0	0	0	1	0	0	1	7
3	FIORINAL W CODEINE	0	1	0	0	0	0	0	1	3	1	1	0	0	0	7
SUB-TOTAL FOR: CSA3		23	22	25	28	22	27	41	22	30	23	24	26	28	28	349
4	DIAZEPAM	217	186	176	227	213	217	212	196	228	240	207	237	243	206	3,082
4	ETHCHLORVYNOL	33	28	29	39	31	40	38	29	32	28	26	32	41	28	476
4	D-PROPOXYPHENE	32	38	26	32	30	29	27	36	23	37	44	28	23	23	451
4	FLURAZEPAM	27	21	25	36	29	34	34	27	28	36	29	34	38	30	425
4	PHENOBARBITAL	24	29	19	23	36	23	21	21	32	33	28	32	23	23	367
4	CHLORDIAZEPOXIDE	28	29	30	32	21	26	27	24	22	25	21	26	29	18	358
4	CLORAZEPATE	11	7	8	6	6	6	11	18	13	12	7	8	11	7	128
4	PENTAZOCINE	10	5	6	10	9	7	8	7	8	6	3	9	4	5	97
4	MEPROBAMATE	3	4	2	7	2	7	5	2	4	2	8	3	6	4	59
4	OXAZEPAM	4	3	5	5	4	3	7	3	8	3	2	2	5	4	55
4	CHLORAL HYDRATE	5	2	4	8	5	7	4	3	2	1	3	3	1	3	51
4	LORAZEPAM	2	0	1	1	1	1	0	0	4	1	2	2	1	3	19
4	DIETHYLPROPION	1	1	0	0	1	0	1	0	0	0	1	0	0	2	7
SUB-TOTAL FOR: CSA4		422	375	331	426	380	398	395	363	401	424	381	416	422	356	5,490
5	DIPHENOXYLATE/ATROPI	1	2	4	2	2	1	2	3	1	2	0	0	0	2	22
SUB-TOTAL FOR: CSA5		1	2	4	2	2	1	2	3	1	2	0	0	0	2	22
6	BELLADONNA/PHENOBARB	7	6	4	4	2	1	3	5	7	3	5	2	7	3	59
6	LIBRAX	2	0	2	0	4	1	4	3	4	1	2	3	1	1	28
SUB-TOTAL FOR: CSA6		9	6	6	4	6	2	7	8	11	4	7	5	8	4	87
8	TEDRAL	0	1	2	2	0	0	4	1	3	0	0	1	1	0	15
SUB-TOTAL FOR: CSA8		0	1	2	2	0	0	4	1	3	0	0	1	1	0	15
9	ALCOHOL IN COMB.	249	238	208	323	278	217	271	248	299	363	281	341	325	301	4,878
9	OTHER DRUG	201	189	210	175	186	207	212	176	201	146	181	228	215	216	2,802
9	ASPIRIN	50	52	52	50	38	49	59	50	37	66	55	35	32	43	668
9	AMITRIPTYLINE	34	37	23	45	40	36	40	43	43	38	42	42	50	36	557
9	CHLORPROMAZINE	30	29	28	25	29	18	31	25	36	35	42	24	37	32	476
9	HYDANTOIN	47	26	14	30	24	18	18	33	37	40	39	40	34	43	463
9	THIORIDAZINE	31	24	17	22	27	18	18	17	21	29	18	31	23	20	316
9	ACETAMINOPHEN	28	23	12	13	25	27	26	12	30	25	23	20	25	25	306
9	HALOPERIDOL	24	17	16	16	15	12	17	17	15	21	13	21	23	23	252
9	TRIFLUOPERAZINE	18	12	12	11	8	12	13	12	18	19	15	9	11	19	191
9	TRANQUILIZER MISC	9	9	7	1	1	4	8	4	19	18	22	28	9	9	144

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****DRUG ABUSE WARNING NETWORK SPECIAL REGIONAL REPORT SERIES**********DRUG ABUSE WARNING NETWORK SPECIAL REGIONAL REPORT SERIES****
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NEW YORK STATE

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CSA SCHED	NAME,	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
9	FLUPHENAZINE HCL	28	7	2	8	4	4	6	7	2	13	10	16	12	10	139
9	IMIPRAMINE	8	4	7	4	9	9	13	12	10	16	7	6	12	13	132
9	DOXEPIN	5	10	7	11	6	14	13	11	11	16	4	9	4	5	126
9	BENZTROPINE	19	4	3	4	5	4	6	6	5	14	12	21	11	10	124
9	LITHIUM CARBONATE	6	6	13	7	8	1	9	9	7	18	8	7	15	13	124
9	METHAPYRILENE/SCOPOL	8	5	14	5	8	6	14	5	11	9	5	7	6	8	111
9	DIPHENHYDRAMINE	18	9	4	9	4	10	3	6	8	3	4	4	7	4	92
9	PERPHENAZINE/AMITRPT	9	7	5	3	5	6	1	9	9	4	8	3	9	5	83
9	INSULIN	8	13	3	3	5	8	0	1	5	11	4	4	1	3	41
9	THIOTHIXENE	2	4	5	2	6	1	2	6	4	3	1	3	10	4	53
9	NYTOL	4	2	8	9	6	3	4	1	2	8	2	3	5	4	52
9	PARNATE	10	16	2	2	0	1	1	2	1	3	0	0	0	0	46
9	PROPANOLOL HCL	7	5	0	7	1	1	4	3	5	0	1	2	4	3	43
9	METHYLDOPA	3	3	7	4	1	1	2	1	4	1	4	2	5	0	38
9	ERYTHROMYCIN	2	8	4	1	3	2	2	4	3	2	2	1	1	2	37
9	PERPHENAZINE	3	3	2	1	2	2	4	3	2	1	0	2	6	5	36
9	HYDROXYZINE	8	2	2	2	0	4	4	2	1	3	3	2	1	1	35
9	CONTAC	3	2	1	3	1	1	1	0	3	7	7	2	1	2	34
9	TETRACYCLINE HCL	7	8	2	3	2	2	3	0	1	0	1	1	2	1	33
9	PENICILLINS POTASSIU	9	11	5	0	1	0	0	1	2	2	2	0	0	0	33
9	AMPICILLIN	10	1	3	2	3	3	3	1	1	1	1	0	1	1	33
9	MIDOL	3	2	2	2	0	0	1	0	1	4	2	4	0	3	32
9	HYDROCHLOROTHIAZIDE	6	6	2	2	0	3	2	3	2	1	2	0	1	2	32
9	FUROSEMIDE	5	3	1	3	3	0	2	4	2	1	2	3	3	0	32
9	DRISTAN	3	2	2	3	1	2	4	0	2	5	3	0	2	2	31
9	TRIMEXYPHENIDYL HCL	6	1	2	6	1	1	3	2	1	1	1	0	2	3	30
9	INDOMETHACIN	1	2	3	1	0	1	4	2	3	2	0	1	4	1	25
9	DISULFIRAM	6	2	0	3	1	3	0	1	4	3	0	0	1	1	25
9	DIET PILL	1	5	2	0	2	5	2	0	1	2	0	1	2	0	23
9	GLUES	0	0	1	3	2	3	2	2	4	2	1	0	0	3	23
9	PRIMIDONE	2	0	0	2	0	0	2	0	6	4	2	1	2	1	22
9	MARAX	0	0	4	1	1	2	3	0	0	3	3	3	0	1	21
9	DIGOXIN	3	0	2	0	1	2	1	4	1	0	3	2	1	1	21
9	ACTIFED	1	2	1	1	0	2	1	4	2	0	3	0	2	1	20
9	CAFFEINE	1	2	0	1	3	1	1	0	1	1	0	2	4	2	19
9	SEDATIVE MISC	0	0	0	0	0	1	0	0	4	3	5	4	2	0	19
9	DIMETAPP	2	2	4	1	1	0	2	4	1	0	0	0	0	1	18
9	CHLORPHENIRAMINE	2	1	1	0	1	1	1	0	2	3	0	1	1	2	16
9	METHOCARBAMOL	0	1	2	1	0	2	2	0	0	2	1	2	3	0	16
9	DESIPRAMINE	2	0	0	1	1	1	1	0	5	1	1	2	1	0	16
9	METHAPYRILENE HCL	0	0	1	0	1	3	4	1	0	1	2	2	0	1	16

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCE ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES IT INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST 90% OF THE DAYS INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

---PREPARED BY THE INFORMATION RESOURCES UNIT, INFORMATION SYSTEMS SECTION, OFFICE OF COMPLIANCE AND REGULATORY AFFAIRS, DRUG ENFORCEMENT ADMINISTRATION (TELEPHONE (202) 633-1336)

NEW YORK STATE

SMSA NAME: NEW YORK

TABLE A - CONSISTENTLY REPORTING EMERGENCY ROOMS

CSA SCHED	NAME	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
9	DIGITALIS	4	6	4	0	0	0	0	0	0	1	0	2	1	0	16
9	PROCHLORPERAZINE	1	4	1	0	1	0	0	1	1	1	2	0	2	1	15
9	NORGESIC	1	1	0	1	0	3	1	1	1	3	0	0	3	0	15
9	ANALGESIC MISC	0	1	1	3	0	0	2	1	2	0	1	2	2	0	15
9	CORICIDIN	1	3	1	0	0	3	1	1	2	0	2	0	1	1	14
9	BROMPHENIRAMINE MALE	1	0	2	1	1	0	0	3	2	4	0	0	0	0	14
9	NITROGLYCERIN	1	2	0	2	0	0	0	1	1	2	2	1	2	0	14
9	ALCOHOL SUBSTITUTES	0	0	0	0	0	1	2	2	1	1	1	0	2	3	13
9	TRIAMTERENE	2	0	3	0	0	0	0	1	0	4	0	3	0	0	13
9	FERROUS SULFATE	1	1	0	1	1	1	1	3	0	1	0	3	0	0	13
9	DIMENHYDRINATE	1	0	1	2	1	2	0	1	0	1	0	2	1	1	13
9	ALLERGY	1	0	4	1	1	1	0	2	0	1	0	0	1	0	12
9	COMBID	3	1	1	0	1	0	1	1	0	0	0	2	1	0	11
9	TRANYLCYPROMINE	1	2	0	1	0	0	0	0	1	0	2	1	3	0	11
9	CEPHALEXIN	1	1	3	0	0	0	2	1	0	1	1	1	0	0	11
9	NOTRIN	4	1	0	0	2	0	1	0	0	0	1	1	1	0	11
9	ORAL CONTRACEPTIVE U	4	2	0	0	0	0	0	0	0	0	1	0	2	1	10
9	CARBAMAZEPINE	0	0	0	0	0	0	0	1	0	2	1	0	2	4	10
9	PHENOTHIAZINE	0	0	3	0	0	2	0	1	0	1	0	0	1	1	9
9	MESORIDAZINE	0	2	0	0	1	3	0	1	0	0	0	0	0	2	9
9	AMINOPHYLLINE	0	1	0	1	0	1	2	0	1	0	1	0	1	1	9
9	WARFARIN SODIUM	1	2	2	0	0	0	1	0	0	0	0	1	1	1	9
9	VITAMIN MISC	0	0	0	0	0	2	0	0	2	0	0	2	1	2	9
9	DIURETICS MISC	1	1	1	0	0	1	1	0	0	1	0	1	1	1	9
9	PREDNISONE	2	0	3	0	0	0	1	0	1	0	1	1	0	0	9
9	PROMETHAZINE	2	0	1	1	2	0	0	0	1	1	0	0	0	0	8
9	GLYCERYL GUAIACOLATE	0	0	3	0	0	0	2	0	0	0	0	0	0	3	8
9	CARISOPRODOL	0	1	0	1	0	1	0	0	1	2	1	0	0	1	8
9	PARAFON	0	0	0	1	1	0	2	0	0	1	0	0	2	1	8
9	MANDIL	0	0	1	0	0	1	2	1	0	0	0	1	0	2	8
9	CHLORPROTHIXENE	0	1	0	0	0	1	0	1	0	0	0	0	3	2	8
9	DOPE	1	0	0	0	1	2	0	0	1	0	1	0	0	2	8
9	PHENYLBUTAZONE	1	1	2	0	0	0	1	0	1	0	1	1	0	0	8
9	CIMETIDINE	1	0	0	0	0	1	0	0	2	1	0	1	0	1	7
9	ANTIBIOTICS MISC	2	1	0	0	0	0	0	2	0	2	0	0	0	0	7
9	PHENOXYMETHYLPENICIL	0	1	0	0	0	0	0	0	3	1	0	1	0	1	7
9	SINUTAB	0	1	2	0	1	0	2	0	0	0	0	0	0	1	7
9	BUTYL NITRITE	2	0	0	0	0	0	1	0	0	3	0	1	0	0	7
9	QUINIDINE SULFATE	0	0	2	1	1	0	1	0	1	0	0	0	1	0	7
9	VITAMINS W IRON	0	0	2	1	0	3	1	0	0	0	0	0	0	0	7
9	CAUSTICS/HOUSEKPING	3	0	1	0	0	0	1	0	1	0	1	2	0	0	7

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCE ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES I INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST 90% OF THE DAYS INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

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PREPARED BY THE INFORMATION RESOURCES UNIT, INFORMATION SYSTEMS SECTION, OFFICE OF COMPLIANCE AND REGULATORY AFFAIRS, DRUG ENFORCEMENT ADMINISTRATION (TELEPHONE (202) 633-1316)

NEW YORK STATE

SMSA NAME: NEW YORK

TABLE A - ALL EMERGENCY ROOMS

CSA SCHED	NAME	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
1	HEROIN	168	125	106	101	112	97	100	106	109	119	124	106	177	167	1,723
1	MARIJUANA	106	118	72	94	73	85	88	63	94	119	81	111	108	125	1,293
1	LSD	36	17	21	23	36	17	34	23	28	61	28	34	32	35	414
1	HASHISH	3	2	2	4	2	2	2	4	2	4	2	2	1	0	32
1	MESCALINE	2	3	1	1	0	1	0	1	1	2	2	4	1	3	22
1	MISC & UNKNOWN HALLU	0	1	1	0	0	1	0	0	2	0	4	3	0	0	12
1	ACID HOOD ROSE SEEDS	1	0	0	0	0	2	0	1	0	0	0	0	0	0	4
1	SPEEDBALL	0	0	0	1	0	0	0	0	1	0	0	0	1	0	3
1	BHT	1	0	0	1	0	0	0	0	0	0	0	0	0	0	2
SUB-TOTAL FOR: CSA1		254	268	203	227	229	204	221	206	227	305	231	301	317	320	3,060
2	METHADONE	159	172	145	173	164	164	113	148	139	168	168	140	136	117	1,673
2	DECOBARB/AMOBARB	97	104	84	86	98	84	84	84	73	94	91	138	156	86	1,335
2	PCP	64	115	63	53	67	73	79	92	103	87	86	97	118	81	1,229
2	COCAINE	53	64	58	70	79	59	59	72	76	73	60	87	79	57	962
2	AMPHETAMINE	23	19	14	23	34	14	32	35	52	41	46	56	63	73	537
2	SECOBARBITAL	27	32	25	21	36	36	29	32	30	32	21	54	28	14	397
2	BARBITURATE SEDATIVE	21	26	30	20	30	26	25	24	28	45	31	32	34	22	396
2	METHAQUALONE	17	20	20	24	21	19	36	34	29	27	25	41	35	37	387
2	BOMBERS	15	3	2	11	9	8	6	12	21	22	21	20	37	47	228
2	OXYCODONE	8	5	6	8	14	13	16	9	7	18	15	19	12	9	157
2	SLEEPING PILL	10	10	4	10	7	9	5	9	11	11	5	6	5	4	106
2	CODEINE	1	4	8	7	1	8	9	6	9	8	7	12	14	9	103
2	MEPERIDINE HCL	6	3	2	8	5	4	8	14	3	7	11	4	7	6	88
2	SPEED	3	7	7	5	6	4	3	5	5	11	4	5	4	4	73
2	PENTOBARBITAL	3	4	4	9	6	7	7	3	3	2	5	7	6	5	71
2	NARCOTIC ANALGESICS	2	4	1	3	6	1	1	3	3	9	4	5	9	3	54
2	HYDROMORPHONE	1	4	4	1	3	7	3	2	3	2	0	3	3	1	37
2	MORPHINE	2	0	1	1	2	1	0	4	1	2	1	1	1	1	18
2	DEXTROAMPHETAMINE	0	2	0	2	2	0	2	1	3	1	1	1	0	1	16
2	AMOBARBITAL	1	0	1	1	0	7	0	0	0	2	0	3	1	0	16
2	METHYLPHENIDATE	1	3	2	2	0	1	0	0	0	2	0	1	2	0	14
2	SYNTHETIC NARCOTIC	0	0	0	0	0	0	0	0	2	2	1	5	0	0	10
2	BARB BLACK BEAUTIES	1	0	0	0	1	0	1	0	1	2	0	0	0	1	7
SUB-TOTAL FOR: CSA2		545	623	490	486	591	477	520	589	602	666	547	709	726	570	8,101
3	BUTALBITAL COMBS	11	7	8	9	7	10	17	2	4	7	5	12	11	9	121
3	ACETAMINOPHEN W CODE	5	5	8	10	6	7	11	11	13	5	7	11	8	4	116
3	GLUTETHIMIDE	3	2	0	3	3	1	6	4	1	5	4	4	3	3	42
3	APC W CODEINE	2	5	5	0	3	3	1	0	2	5	3	0	5	5	39
3	METHYPRYLON	0	0	4	4	4	4	6	3	5	0	3	0	2	3	30

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCE ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES IT INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST 90% OF THE DAYS INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

---PREPARED BY THE INFORMATION RESOURCES UNIT, INFORMATION SYSTEMS SECTION, OFFICE OF COMPLIANCE AND REGULATORY AFFAIRS, DRUG ENFORCEMENT ADMINISTRATION (TELEPHONE (202) 633-1316)

NEW YORK STATE

SMSA NAME: NEW YORK

TABLE A - ALL EMERGENCY ROOMS

CSA SCHED	NAME	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
3	BUTABARBITAL	1	2	8	0	0	1	0	2	0	0	1	2	0	1	19
3	HYCODAN	1	1	0	2	0	1	0	0	0	0	1	0	0	1	7
3	FIORINAL W CODEINE	0	1	0	0	0	0	0	1	3	1	1	0	0	0	7
SUB-TOTAL FOR: CSA3		23	25	28	28	23	27	41	23	30	26	28	29	29	28	380
4	DIAZEPAM	224	187	187	238	217	210	222	199	244	246	210	242	246	206	3,093
4	ETHCHLORVYNOL	34	34	29	39	31	48	35	29	34	29	28	32	42	28	487
4	D-PROPOXYPHENE	35	46	26	33	38	31	27	36	26	38	45	28	24	23	462
4	FLURAZEPAM	28	23	29	36	38	35	35	30	31	37	38	34	35	36	439
4	PHENOBARBITAL	28	31	19	23	36	22	21	22	33	33	28	32	23	23	374
4	CHLORDIAZEPOXIDE	28	31	38	33	23	27	27	26	24	28	21	26	29	18	371
4	CLORAZEPATE	12	8	9	6	7	6	12	15	13	13	8	6	14	7	136
4	PENTAZOCINE	10	9	7	12	9	7	8	7	9	6	3	10	5	5	103
4	MEPROBAMATE	3	4	2	8	3	7	5	2	4	2	6	3	4	4	61
4	OXAZEPAM	4	3	6	5	4	3	7	3	5	3	2	2	8	4	56
4	CHLORAL HYDRATE	5	3	4	6	5	7	4	3	2	1	3	4	1	3	53
4	LORAZEPAM	2	0	1	1	1	1	0	0	4	1	2	2	1	3	19
4	DIETHYLPROPION	1	1	0	0	1	0	1	0	0	0	1	0	0	2	7
SUB-TOTAL FOR: CSA4		434	400	345	439	397	484	487	372	429	437	389	423	431	354	5,663
5	DIPHENOXYLATE/ATROPI	1	2	4	2	2	1	2	3	1	2	0	0	0	2	22
SUB-TOTAL FOR: CSA5		1	2	4	2	2	1	2	3	1	2	0	0	0	2	22
6	BELLADONNA/PHENOBARB	8	4	4	4	2	2	3	4	0	3	5	2	7	3	63
6	LIBRAX	2	2	2	0	4	1	4	3	4	1	2	3	1	1	28
SUB-TOTAL FOR: CSA6		10	6	6	4	6	3	7	9	12	4	7	5	8	4	91
8	TESRAL	0	1	2	2	0	0	4	1	4	0	0	2	1	0	17
SUB-TOTAL FOR: CSA8		0	1	2	2	0	0	4	1	4	0	0	2	1	0	17
9	ALCOHOL IN COMB.	293	339	299	306	280	215	274	243	317	371	284	343	383	385	4,132
9	OTHER DRUG	208	193	219	176	188	207	213	177	211	203	192	238	217	218	2,852
9	ASPIRIN	52	52	52	51	38	50	59	50	38	79	57	35	33	44	601
9	AMITRIPTYLINE	[illegible]	38	23	46	40	37	40	43	47	38	42	42	51	36	565
9	CHLORPROMAZINE	32	34	25	25	30	18	32	26	37	35	42	24	40	53	493
9	HYDANTOIN	47	26	14	30	24	11	18	33	37	40	39	40	34	43	464
9	THIORIDAZINE	31	24	18	23	27	18	19	17	21	29	18	31	23	20	319
9	ACETAMINOPHEN	21	23	12	18	25	20	26	12	32	26	23	20	28	25	313
9	HALOPERIDOL	24	17	16	16	19	13	17	17	15	21	15	22	23	23	254
9	TRIFLUOPERAZINE	18	13	12	11	8	12	15	12	18	19	15	9	12	19	193
9	TRANQUILIZER MISC	9	9	7	1	1	4	1	7	19	18	22	20	9	9	146

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCE ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES IT INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST 90% OF THE DAYS INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

08-06-79

TABLE A - ALL EMERGENCY ROOMS

CSA SCHED	NAME	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
9	GUANIDINE SULFATE	0	0	2	1	1	0	1	0	1	0	0	0	1	0	7
9	CAUSTICS/HOUSEKPING	1	0	1	0	0	0	1	0	1	0	1	2	0	0	7
9	CYPROHEPTADINE	0	0	2	1	1	0	0	1	1	0	1	0	0	0	7
9	ISOSORBIDE DINITRATE	1	0	0	0	1	1	1	0	0	0	0	0	2	1	7
9	CHLORTHALIDONE	2	1	0	0	0	0	0	0	1	0	0	0	1	0	7
SUB-TOTAL FOR: CSA9		1,087	871	788	834	883	755	881	880	969	1,119	898	1,011	1,046	1,042	12,020
TABLE TOTAL		2,324	2,191	1,871	2,024	2,051	1,871	2,083	2,093	2,274	2,501	2,089	2,538	2,529	2,330	30,662

DAWN : Medical Examiner Reports

****DRUG ABUSE WARNING NETWORK SPECIAL SEASONAL REPORT SERIES**************DRUG ABUSE WARNING NETWORK SPECIAL SEASONAL REPORT SERIES****
---PREPARED BY THE INFORMATION RESOURCES UNIT, INFORMATION SYSTEMS SECTION, OFFICE OF COMPLIANCE AND REGULATORY AFFAIRS, DRUG
ENFORCEMENT ADMINISTRATION (TELEPHONE (202) 633-1216)

NEW YORK STATE

SMSA NAME: NEW YORK

TABLE A - ALL MEDICAL EXAMINERS

CSA SCHED	NAME.	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
1	[illegible]	7	1	1	1	0	1	1	0	1	1	1	1	1	0	14
SUB-TOTAL FOR: CSA1		7	1	1	1	0	1	1	0	1	1	1	1	1	0	14
2	METHADONE	15	0	0	0	0	1	1	1	0	0	0	0	0	0	18
2	DEXTROPROPOXYPHENE	11	0	0	0	0	0	0	0	0	0	0	0	0	0	11
2	SECOBARBITAL	5	0	1	1	1	2	0	3	0	1	2	0	0	0	16
2	NARCOTIC ANALGESICS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	CODEINE	0	1	0	0	0	1	0	0	0	1	0	0	0	0	3
2	COCAINE	2	0	0	0	0	0	1	0	0	1	0	1	0	0	5
2	PENTOBARBITAL	1	0	0	0	0	0	0	0	0	1	1	0	0	0	3
2	MEPERIDINE HCL	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2
2	AMOBARBITAL	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
2	HYDROCODONE	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
2	METHAQUALONE	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
2	BARBITURATE SEDATIVE	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
2	HYDROMORPHONE	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
2	PCP	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
SUB-TOTAL FOR: CSA2		43	4	3	3	4	3	2	5	3	4	4	4	0	0	82
3	METHYPRYLON	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
3	BUTABARBITAL	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
3	BUTALBITAL	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
3	GLUTETHIMIDE	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
SUB-TOTAL FOR: CSA3		0	1	0	0	1	0	1	0	0	0	0	1	0	0	4
4	BENZODIAZEPINE	0	2	0	0	3	0	0	1	0	6	1	1	1	0	15
4	D-PROPOXYPHENE	1	2	0	2	2	0	1	1	0	2	3	1	0	0	15
4	PHENOBARBITAL	1	2	0	0	2	1	0	1	1	2	0	0	0	0	10
4	ETHCHLORVYNOL	4	0	0	0	1	0	0	0	1	1	0	0	0	0	7
4	DIAZEPAM	2	0	0	0	0	1	0	0	0	1	1	1	0	0	6
4	FLURAZEPAM	3	0	0	1	0	0	0	0	0	0	1	0	0	0	5
4	MEPROBAMATE	0	0	0	0	0	0	0	0	1	0	1	1	0	0	3
4	DESMETHYLDIAZEPAM	0	0	0	0	0	0	0	0	0	1	0	1	0	0	2
4	CHLORAL HYDRATE	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
4	CHLORDIAZEPOXIDE	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
4	PENTAZOCINE	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
SUB-TOTAL FOR: CSA4		13	6	0	3	9	2	1	3	3	13	8	5	1	0	67
5	ALCOHOL IN CONJ.	11	0	1	1	0	1	0	0	0	0	0	0	1	0	17
5	ANTIHISTAMINE	4	1	0	0	1	0	0	0	1	0	0	0	0	0	17
9	ASPIRIN	2	1	0	3	1	0	0	0	2	2	2	1	0	0	14

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCES ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES IT INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST SIX OF THE DATA INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

08-06-79

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****DRUG ABUSE WARNING NETWORK SPECIAL REGIONAL REPORT SERIES****DRUG ABUSE WARNING NETWORK SPECIAL REGIONAL REPORT SERIES****
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TABLE A - ALL MEDICAL EXAMINERS

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9	QUINIDINE	6	1	0	1	0	0	0	0	0	1	0	1	0	0	10
9	DOXEPIN	3	1	2	0	0	0	0	0	0	1	0	0	0	0	7
9	THIORIDAZINE	2	1	1	0	0	0	0	0	1	0	1	0	0	0	6
9	ACETAMINOPHEN	0	2	0	1	0	0	0	0	0	2	1	0	0	0	6
9	IMIPRAMINE	1	0	0	0	1	1	0	0	1	1	0	0	0	0	5
9	PHENOTHIAZINE	3	0	0	1	0	0	0	0	0	0	0	0	0	0	4
9	METHAPYRILENE HCL	2	1	0	0	0	1	0	0	0	0	0	0	0	0	4
9	NORTRIPTYLINE	0	0	0	0	1	0	0	0	0	1	0	1	0	0	3
9	CHLORPROMAZINE	0	0	0	0	1	0	0	1	0	0	0	0	0	0	2
9	HALOPERIDOL	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
9	LIDOCAINE	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
9	STRYCHNINE	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
9	PHENACETIN	1	0	0	0	0	0	0	0	0	1	0	0	0	0	2
9	TRICHLOROETHYLENE	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
9	CONTAC	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
9	HYDROXYZINE	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
9	CHLOROQUINE	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
9	TRANYLCYPROMINE	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
9	DESIPRAMINE	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
9	DIGOXIN	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
9	HYDANTOIN	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
9	LITHIUM CARBONATE	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
9	QUINIDINE SULFATE	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
SUB-TOTAL FOR: CSA9		47	10	5	0	0	5	3	1	5	13	10	7	1	0	123
TABLE TOTAL		110	24	9	16	22	14	7	9	12	35	25	19	3	0	305

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCE ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES IT INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST 90% OF THE DAYS INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

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New York Times, September 14, 1979

Sales of Illegal Drugs in the City Are Found to Be Commonplace

By SELWYN RAAB

As soon as the blue sedan double-parked at 116th Street and Lenox Avenue, the driver honked his horn twice and waved a handful of bills out the window. A man who had been on the sidewalk took the cash in exchange for two small glassine envelopes that were apparently filled with heroin.

On that same recent sunny afternoon, a group of youths stood on a grassy fringe of Forest Park in Queens peddling "tins," or cocaine, to passers-by.

And, virtually in the shadow of Police Headquarters in lower Manhattan, outside Pace University on Frankfort Street, another aspect of New York City's illegal drug trade was easily observed. Clusters of young men and women lighted "joints," or marijuana cigarettes, after buying them from a vendor who kept his supply in a package strapped to his ankle.

These types of undisguised street sales of narcotics and drugs have become commonplace in the city. Despite statements by high-ranking police officials that a three-year-old campaign to rid the streets of dealers has largely succeeded, many experts and narcotics investigators believe that the overall drug-control problem in the city has worsened in the last two to three years.

"If this is a war, then we're losing," said Sterling Johnson, the city's special narcotics prosecutor. "There are more drugs on the streets than ever before."

"It's all over, not just Harlem," according to Dr. Mitchell Rosenthal, the director of Phoenix House, the largest private drug-rehabilitation program in the city. "Drugs have become an accepted part of the city's landscape."

Many law enforcement experts acknowledge that the harsh penalties of state laws drafted during Gov. Nelson A. Rockefeller's administration and imposed in 1970 have failed to discourage street sales of drugs. Experts like Julio A. Martinez, the director of the state's Substance Abuse Services, said that because of the huge demand for drugs — and the resulting high profits — many street dealers, or pushers, were seemingly unafraid of being arrested.

The Police Department's Narcotics Division and the Federal Drug Enforcement Administration concentrate most of their manpower against dealers doing large amounts of business, not small-level street pushers. Although the figures are confidential, the number of city police officers and Federal agents assigned to drug enforcement has been cut during the last five years because of budget restraints.

Summing up the views of most rehabilitation officials, Mr. Martinez said: "A few years ago all we had out there was heroin. Now everything is for sale: heroin, coke, methadone, marijuana, pills. It's an open pharmacy, and no one is afraid of being arrested."

Mr. Martinez, who is a former heroin addict, said that on inspection tours of the Union Square area and in Harlem he had been solicited by drug dealers. "When I was pushing I never approached someone I didn't know," he noted. "Today, no one is afraid of the cops."

Open sales of drugs and marijuana were also observed by The New York Times in many neighborhoods. Among these were: in Queens, on Jamaica Avenue, on Flushing Avenue, in Alley Pond Park and in Cunningham Park; in Brooklyn, on Fulton Street, Eastern Parkway and Broadway; in Manhattan, at the Avenue of the Americas entrance to Central Park, at 8th Street and Third Avenue and in Times Square.

Street sales also were widespread in Harlem, which law enforcement experts

The New York Times

Sterling Johnson, New York's special narcotics prosecutor. "There are more drugs on the streets than ever before," he says.

said remained as the major center for large- and small-scale heroin transactions in the metropolitan area.

However, Charles H. Kelly, a deputy police chief who is in charge of the Police Narcotics Division, said efforts against street dealers or "pushers" had been effective. "I know I'm sticking my neck out, but I think the situation is under control," Chief Kelly said. "What you see is isolated pockets. I think we have driven most of the pushers off the streets."

According to Federal and city law enforcement officials, these significant changes in narcotics and drug trafficking in the city have developed recently:

¶The police report that arrests of cocaine dealers, a rare occurrence a few years ago, have increased dramatically while arrests of heroin dealers have declined. The Police Narcotics Division, which makes most of the major drug-dealer arrests in the city, pulled up 1,[illegible] persons on cocaine charges and [illegible] on heroin charges last year. Because there were so few cocaine arrests in the early 1970's, separate records for indictments on cocaine charges were not kept. Investigators attributed the upsurge in cocaine-related arrests to the growing popularity of cocaine among young people and middle-income groups who consider it a "chic" drug, an increasingly abundant supply of the drug and the declining use of heroin.

¶Investigators say that cocaine is no longer "the champagne drug," increasing demand has brought with it an increased supply, and the average street price is now $50 to $60 for two to five grains — about half the price of three years ago.

¶ Officials in the Federal Drug Enforcement Administration said that for the first time in at least five years large supplies of heroin were believed to be entering the city again from Europe and the Middle East. Simultaneously, the destruction by the Mexican Government of much of the opium crop in Mexico, from which heroin is derived, has virtually eliminated Mexican heroin in New York. The officials said they were concerned that the resumption of trafficking between Europe and the United States indicated that organized-crime leaders recently released from prison were again involved in large-scale heroin smuggling, as they had been in the early 1970's.

¶The police report widespread use by low-level dealers in marijuana and cocaine in Brooklyn and the Bronx of "smoke shops," or street-front stores, to sell their wares. Chief Kelly said that in many of these stores the dealers operated from behind bullet-resistant enclosures to protect themselves from robbers and to conceal themselves from the police. The barricades, he said, make it difficult for the police to seize drugs as evidence before they can be destroyed or to identify dealers, who hide their faces behind the barricades. About 140 "smoke shops" are believed to exist, Chief Kelly said.

¶Federal investigators say an organized-crime group from the New York area for the first time is deeply involved in large-scale smuggling of marijuana by ships and trucks into the metropolitan area. According to officials of the Drug Enforcement Administration, the group is an organization once led by the late Joseph Colombo of Brooklyn and now believed to be run by John Franzese.

The two agencies that are most responsible for combatting drug traffic here are the Police Narcotics Division and the Federal Drug Enforcement Administration. The police division normally has about 500 officers and detectives assigned to undercover work, intelligence and clerical duties.

The Federal drug agency has 147 field agents assigned to the city and the suburbs. Both units have suffered personnel cuts since the early 1970's, when the law enforcement drive against narcotics was at a peak.

'Quality of Arrests Is Down'

Chief Kelly said the number of plain-clothes officers from his unit normally assigned to stopping street or small-level dealers was "confidential." However, other police officials estimated that about 100 narcotics undercover officers are regularly assigned to undercover street-enforcement in the city, with the remaining 400 officers in the division working on cases involving large and middle-echelon dealers.

Chief Kelly, who has commanded the narcotics division since last January, said that a three-year police drive against street sales in Harlem, called "Operation Drug," and "crackdowns" in other neighborhoods had driven dealers, especially heroin "pushers" off the sidewalks. Citing a decline in narcotics-related deaths in the city over the last four years to 200 from 900, he added:

"We've had a tremendous impact. The dealers now have to barricade themselves in peephole operations and are more afraid than ever to sell. Given the laws we have to work with, and the magnitude of the problem, conditions are much better than in 1970 or earlier."

But, other law enforcement officials and undercover agents in Chief Kelly's division disputed his assessment.

David Cunningham, chief assistant to Mr. Johnson, the special narcotics prosecutor, said that the number of indictments secured by his office had fallen to 1,[illegible] last year — a drop of almost 200 in two years. "The number and quality of arrests we are getting from the police is way down," Mr. Cunningham asserted.

Mr. Johnson said that because of a lack of "buy money" and revised state laws that went into effect on Sept. 1, street arrests would be more difficult. The new laws require larger sales — two ounces instead of one ounce of cocaine and heroin — for major felony indictments or, upon conviction, the maximum term of life imprisonment.

The police will have "even more trouble busting even medium-level dealers," Mr. Johnson said. For an ounce of the best heroin or cocaine undercover agents may have to pay as much as $10,000, he noted, an amount of money the police often find difficult to obtain.

"Sure, the pushers are less clandestine than five or 10 years ago," said Michael J. Cassidy of the Federal agency's intelligence division in New York. "The drug consumers want their merchandise with relative ease and they are not worried about being arrested," he said, adding. "The consumer has forced the traffickers to become bolder and bolder."

Dr. Rosenthal, who has been the head of Phoenix House rehabilitation program for 13 years, said the current "street conditions are the explicit effects of police policy to go after the big generals and ignore the street pushers."

"Being a drug salesman has become a good, almost accepted way of life," he asserted, adding. "In the last couple of years, drug use has become woven into the fabric of the culture, with little appreciation that it is a symptom of anything being wrong. A lot of lives are being unraveled because there is a cultural delusion that if you have the right dealer, your health won't be affected and no one will have to pay any dues."

Illegal-Drug Costs on the Street

Federal officials believe that about $9 billion will be spent on illegal purchases of cocaine, heroin, marijuana and hashish in the New York metropolitan area this year.

According to the Police Department's Narcotics Division, a kilo, or 2.2 pounds, of cocaine at 30 percent purity will cost a dealer a minimum of $[illegible]. A kilo of 50 percent pure heroin will cost a minimum of $[illegible] and the price of a pound of marijuana varies between $[illegible] to $[illegible].

A kilo of heroin or cocaine can be diluted into enough portions to gross about $[illegible] in street sales.

On the street, undercover agents say the most common prices are: a "quarter bag" of heroin, 20 to 30 grains, $25 or $30; a "tin" or 2 to 5 grains of cocaine, $10 to $20, and a marijuana "joint" or cigarette, $1.

Heroin is the only narcotic sold on the street under brand names, such as "Midnight Express," "Death Boy," "Black Sunday," "Watergate Blue" and "Watergate Red."

The fight against heroin remains the No. 1 priority for the Federal Drug Enforcement Administration — despite the growing use of cocaine — because heroin is believed to be a more harmful and potentially fatal drug.

Federal officials, while cautioning that there are no accurate figures, believe there may be as many as 100,000 heroin addicts in the city and 400,000 in the country. Larger numbers are believed to be regularly using cocaine and marijuana, but no accurate figures are available.

U.S. Drugs Chief, in West Berlin, Warns of New Mideast Opium Threat

Special to The New York Times

WEST BERLIN, Oct. 11 — A "tremendous harvest" of about 1,000 tons of raw opium from Middle East countries, primarily Pakistan, Afghanistan and Iran, is expected to hit illicit drug markets this year, posing grave new problems for Western Europe and the United States, Peter B. Bensinger, head of the Drug Enforcement Administration in Washington, said here today.

Mr. Bensinger said that since last year the Middle East had become the world's main supplier of illicit heroin, overtaking the so-called Golden Triangle in Southeast Asia, the border regions of Burma, Thailand and Laos, once the largest drug-producing area.

Talking to reporters, he said drug enforcement programs in the Middle East had encountered particular difficulties because "of the degree of political instability" in that region. Afghanistan and Iran, and to some degree Pakistan, have been swept by political and social turmoil in recent months.

The American official came to Europe at a time of an alarming rise in drug addiction on the Continent and in Britain, a development that led to more than 1,500 drug-related deaths in Western Europe last year.

Addiction Decreases in U.S.

He said that compared to the upward trends in Europe a "dramatic decrease" in heroin availability had been achieved in the United States, resulting in a drop in heroin addiction from about 500,000 people 10 years ago to perhaps 450,000 this year. He noted that the death rate related to heroin abuse was lower in the United States now than in West Germany alone, and stood at about 30 victims per month.

The American official, who conferred in Bonn yesterday with Gerhard Baum, the Interior Minister, and with law officials, praised cooperation between the two countries on drug control.

For some time, special United States and West German teams have worked together to penetrate illicit drug rings, involving American servicemen, West German civilians and dealers from the Middle East.

In West Berlin, Mr. Bensinger attended a conference of some 80 American officials and diplomats on the problems related to illegal drug traffic.

Goes to Rome Next

Mr. Bensinger, who is going to Rome next to confer with Italian officials on narcotics, noted that the improvement in the heroin problem in the United States stemmed largely from successes in curbing opium production in Mexico.

He warned that the new wave of illicit drugs emanating from the Middle East "may well end in the United States and change recent drug history."

He said favorable developments in Mexico and Southeast Asia had been brought about by strict law enforcement programs. In addition, crops from the Golden Triangle area had been severely hit by continuing drought in the Far East.

At present, most of the Middle East drug production is smuggled to Europe, frequently coming by way of Turkey, the Balkans and East Germany to West Berlin and West Germany. Last year, the Bonn Government reported 420 deaths that resulted from heroin abuse. "The easy availability of heroin in Germany may relate directly to the large number of Turkish laborers in the country," Mr. Bensinger noted.

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NEWSWEEK
November 26, 1979

A BAN ON DRUG PARAPHERNALIA?

In his faded jeans and racing-car T shirt, Reese Trammel looked like any other customer at the Pester Hut, an Atlanta head shop that deals in drug paraphernalia. He studied the displays of brightly colored bongs, carburetor pipes and spoons, then bought a book on the pleasures of cocaine and a bottle of mannite powder used to "step on," or dilute, cocaine. But Trammel is an undercover cop, and as soon as he had made his purchases, four detectives burst in, a TV news crew at their heels. They arrested the shop's owner and his clerk and confiscated $5,000 worth of drug-related accessories. It was the ninth head shop raided in four months, leaving just two operating in the Atlanta area.

The crackdown in Atlanta is exceptionally tough, but efforts are under way all around the country to snuff out sales of bongs, boosters, roach clips, vials, pipes, spoons, seales, straws, stash cans and other assorted accouterments of the illegal drug culture. Several states and hundreds of communities have enacted some type of law—ranging from sweeping bans to restrictions on displays—aimed at dismantling the paraphernalia industry, estimated at several hundred million dollars a year. Many stores are taking drug-related items off the shelves; last week, two Washington, D.C., drugstore chains stopped selling cigarette-rolling papers frequently used for marijuana, and many 7-Eleven stores discontinued them in September. Senate hearings are being held on regulating the accessories business, and the Drug Enforcement Administration has drafted a model law to help communities crack down. "The paraphernalia industry fans the fire of the growing drug-abuse problem," declares DEA administrator Peter B. Bensinger. "The need for restrictions on the availability of the merchandise is clear."

GLAD BAGS: But the constitutionality of such restrictions is not so clear. Paraphernalia purveyors—some 30,000 retailers—argue that there is nothing inherently illegal about their wares. Backed by batteries of lawyers and civil-liberties groups, dealers have knocked down many of the laws in courts—often on the ground that they violate due process by punishing people on the mere assumption that they will take drugs. Head-shop owners say they are being discriminated against, since many household items can also be used for drugs. "Glad Bags could be openly bought as drug paraphernalia, but who would arrest a grocer?" says Chicago attorney Michael Pritzker.

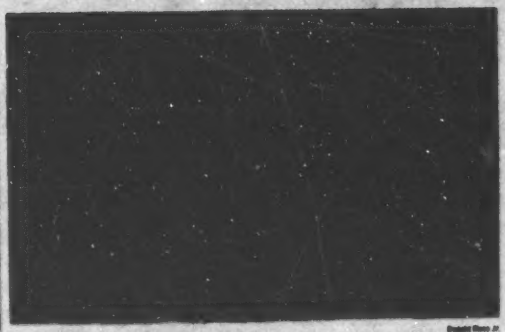
Critics argue that head shops openly encourage drug use. "How do you convince a kid to stay off drugs if on the way to school he sees a head shop with pipes, papers and pictures of marijuana?" asks New York state senator Frank Padavan, who has proposed a ban in New York. Distressed parents say that such head gear as instruction books and training kits complete with phony pot blatantly teach young people to use drugs. They point with alarm to the dazzling array of "power-hitters," "phaser guns" and "iodizers" designed to increase drug potency. "It's simple," says Padavan. "Head shops and drug abuse go hand in hand."

Local legislators have found that the more specific the law, the better chance it has of standing up in court. A Federal court upheld a Novi, Mich., statute, for example, that prohibits devices "primarily adapted or designed" for use with illegal drugs—including such items as a spoon with "a bowl so small as to be unsuited for the typical lawful use of a spoon." The DEA's model law defines drug paraphernalia carefully and bans their manufacture and sale.

Justice Department officials warn that even the DEA's law may still be found unconstitutional, and that communities may have trouble enforcing such a sweeping ban and proving "intent" to use drugs. Irvin Nathan, a deputy chief of the Justice Department's criminal division, says that local governments should also explore simply restricting head shops with zoning ordinances or license requirements. But paraphernalia dealers recently won a temporary injunction against even such milder measures in Westfield, Mass.

BEST GLASSES: Even if constitutional laws against paraphernalia could be drafted, accessories dealers say that a crackdown on gadgets would do little to stem the rise of drug use. Many head-shop critics sadly agree. "Any 15-year-old knows that you don't need pipes and papers to do drugs," says Amherst, Mass., attorney Richard Evans. The drugs themselves are illegal, yet government statistics show that one in five Americans have tried marijuana, one in ten use it regularly, and one in 22 have tried cocaine. At best, the crackdown on paraphernalia can alter the climate of permissiveness that perhaps encourages youngsters to take drugs. But it is unrealistic to expect head-shop laws to make much of a dent in drug use—any more than a ban on shot glasses could solve the problem of alcoholism.

MELINDA BECK with
ELAINE SHANNON in Washington,
MARC FRONE in New York and bureau reports



Dwight Ross Jr.

Police close down an Atlanta head shop: Critics say the law is unconstitutional

ACCIDENTAL DRUG ADDICTION

HARPER'S BAZAAR August 1978

BY MURIEL NELLIS

Relying on drugs to solve our problems, whether physical, mental or emotional, is as common as social drinking. One woman in five may be accidentally addicted to her legally prescribed medication. Habitual use—especially in combination with other drugs or alcohol—is causing more physical damage and death than any of the "street" drugs we associate with drug abuse.

Former First Lady Betty Ford has once again performed an enormous public service by focusing the nation's attention on a major medical problem—that of accidental addiction to prescribed medications and the perilous consequences of combining drugs and alcohol. Mrs. Ford's courageous admission of her own dependence on Valium and alcohol has created a public awareness which will affect the lives of millions of women.

It is estimated that *one in every five women* may be accidentally addicted to her medication. Legally prescribed drugs, taken in dangerous combinations or with alcohol, are causing greater physical damage and death than any of the illegal drugs generally associated with drug abuse.

Mrs. Ford's extraordinary candor is particularly timely because she has awakened the public mind to a problem which has been growing rapidly for the past 20 years—one that is not unique. Rather, Mrs. Ford's dilemma is a contemporary classic. In our society, reliance on drugs is as commonplace as the consumption of food or the use of alcohol for special occasions.

Prescription drugs have now become the mainstay of medical care. A staggering number of medications have been developed to treat pains and discomforts of every kind and almost without exception they affect the brain to some degree. Depending on the user's physical or emotional state, metabolism, hormonal balance, age and frequency of use, they may produce various side effects, mildly discomforting to fatal. And all are potentially habit-forming. The trouble is the user has no sure way of knowing any of these possibilities.

Over-the-counter remedies, which people tend to think of as harmless, often are used simultaneously with prescription drugs and liquor, without regard to their combined chemical actions. Since all drugs are potentially toxic, the use of several medications, either simultaneously or in close sequence to each other, adds further risk due to the drugs' interaction. (The word often used to describe this combined action is "synergism"—it means that the combination of two or more drugs produces an effect *greater* than the sum of the effects of the individual drugs.) Such combinations are known to make an increased demand on the body's normal responses and functions. Often, it becomes impossible to determine exactly which element has caused an unexpected and dangerous reaction.

• MOOD-ALTERING DRUGS

Of the 1.4 billion prescriptions filled in the U.S. in 1977, approximately 30 per cent were specifically of the psychoactive (mood-changing) variety: 16.8 million stimulants, including appetite suppressants, and depressants—ranging from sleep-inducing sedatives to 98 million minor tranquilizers—are counted in this category. Another class of drugs in common use which may cause addiction are the analgesics (pain-killers).

All these drugs act on the central nervous system. They are often overprescribed, and misuse can lead to dependence. Among the stimulants, some of the better recognized brand names are Dexedrine, Preludin, Ritalin; sedatives include Doriden, Nembutol, Seconal; the major tranquilizers are Thorazine, Stelazine, Mellaril; the minor tranquilizers, Valium, Librium, Equanil; and analgesics include Equagesic, Darvon, Percodan and Talwin. Valium and Librium, in particular, are used with at least one other prescribed drug more than half of the time.

Prescriptions for mood-altering drugs are disproportionately high among women because they constitute the largest group of patients seeking medical advice. It is known that women will reach for and accept help at critical points in their lives which may heighten their dependence on medical advice. Marriage, birth and motherhood, separation, divorce, menopause or major surgery often result in psychosocial and physical stress. Since women, unlike men, are encouraged to admit distress, they are more frequently diagnosed as having "non-specific anxiety" and are given tranquilizers. The majority of physicians issuing these prescriptions are not psychiatrists. They are general practitioners, internists and obstetrician/gynecologists, doctors who are the primary health-care advisers of women, and who themselves have only limited expertise in pharmacology and psychopharmacology.

A recent government study for the assessment of the drug and alcohol problems of women is especially critical of the tendency of physicians to "help" women by prescribing anxiety-reducing drugs as an adjunct to other medical treatment. Researchers observed that the most common emotional problems of women who become addicted are feelings of isolation, low self- (CONTINUED ON PAGE 188)

"Life is a series of stages, crises, developments, passages of constant change and challenge. The human response most commonly experienced in dealing with these unavoidable realities is tension and anxiety.

"Where to turn and what to do about these uncomfortable feelings and sensations is an age-old problem. Today, a dangerous trend is the increasing use of chemicals—either in the form of a self-sought and bought over-the-counter drug that promises relief, or in the solicitous, but inappropriate, prescription of powerful mood- and consciousness-altering drugs by physicians.

"Drugs, as a coping mechanism, offer short-term help coupled with long-term danger. This is not to say that drugs have not proven helpful for serious depressions and other mental illnesses. They have indeed. But for life's everyday problems (and they can be painful) the support of sympathetic friends and relatives, specialized organizations and spiritual solace are preferable to habitual reliance on drugs in any form."

Herman E. Brown, M.D.
Assistant Surgeon General

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ACCIDENTAL DRUG ADDICTION

CONTINUED FROM PAGE 56

esteem and depression, largely born of frustration. This compares favorably with earlier findings that there are few differences between the vulnerability of housewives and working women—but that there are striking similarities in the misuse of legal drugs by women living in solitary situations. With that information in mind, doctors should exercise caution in prescribing these drugs casually.

• MEDICAL FALLIBILITY

Until very recently, most people presumed that, with all of the regulations governing prescriptions in this nation, any available drugs must be safe and effective. It was also thought that if drugs were prescribed by a trusted, licensed physician, they must be therapeutic. In addition, the safety of these drugs was taken for granted because of their easy availability and the liberal instructions to take them "as needed."

How often have busy doctors taken the time to explain the appropriate use of a drug, the duration of each dose, any possible side effects and other drugs which should be avoided? By their own admission, doctors are primarily trained to diagnose and treat physical illness. Only recently has medic.[illegible] education begun to teach how to treat psychic stress. Most physicians haven't taken a course in pharmacology since the second year of medical school and have not been required to brush up since then.

Knowledge of the psycho-active drugs is largely transmitted to the medical profession by magazine articles, medical journals and their advertisements and salesmen representing drug manufacturers. Over the years the drug industry "pitch" has portrayed women as anxious, depressed and needing special symptomatic treatment. In medical-journal ads, the tranquilizers have been proposed as "relatively safe" for everything from youthful menstrual anxiety to such environmental stresses as urban density or midlife blues. While the pressure to prescribe these panaceas is obvious, the superficial understanding of their chemical nature is profoundly disturbing.

Dr. Leo Hollister, a renowned California psychiatrist, has often cautioned that anti-anxiety drugs are particularly insidious. He estimates that the body develops a tolerance to them within just a week or two and that they then leave a residue in the bloodstream which lasts from 60 to 120 hours. He has suggested that the uninterrupted use of large doses of Valium or Librium is likely to produce a physical dependency sufficient to cause convulsions if stopped suddenly.

Experts in the study of alcoholism have often deplored the overprescription of sedative drugs since, like alcohol, they are central nervous system depressants. It is important to understand the competition between sedatives and alcohol in the body. The same liver enzymes are necessary to metabolize both substances and they cannot do both jobs at once. Thus, even moderate drinking at a cocktail party followed by a prescribed dose of sleeping pills may result in an accidental, lethal overdose.

The death in 1965 of columnist Dorothy Kilgallen was a case in point. The medical examiner's report said "Miss Kilgallen died of the effects of a combination of alcohol and barbiturates, neither of which had been taken in excessive quantities." In recent years, there have been other well-known personalities whose drug-related deaths have been sensationalized or portrayed as part of their exotic lifestyles. Perhaps a closer look in their medicine cabinet, would have been instructive.

• WOMEN'S RESPONSIBILITY

Although a great deal of information is now available, important basic questions remain unanswered which have particular meaning for women. The influence of hormonal functions on drugs must be studied. Are there certain body cycles which may foster or heighten addiction? Does a state of stress or depression alter brain waves and affect the body's chemistry? Are there implications for drug-reliant or craving behavior? Future directions for safe use of all mood-altering drugs may very well depend on a better understanding of our uniquely sophisticated hormonal system.

In the meantime, we must all acknowledge that we live in an age of increasingly complicated medical technology. We must examine it carefully for our own personal health and safety. We live in a system in which physicians must see a great number of patients a day or fail economically. It is a society in which drug companies spend millions of dollars persuading us all of a pleasanter life through chemistry. In pursuit of the good life and a state of well-being, millions of American women have become dependent on drugs to varying degrees.

While we must hope that this new survival-consciousness will continue and that our public and private medical institutions will begin to review their shortcomings, we must begin to take some individual responsibility for ourselves.

Here are some basic points to be aware of when taking medications of any kind.

- Begin to question the properties of any chemicals that you ingest, especially those which affect your moods. Alcohol is a mood-depressant.
- Be alert to danger signals. Begin with an understanding of what constitutes health for you in particular, notice and act upon any drug-induced changes in your inclinations, disposition, and reactions.
- Insist on your right to know, in order to share responsibility for your health. Request better verbal and written information about prescribed therapies, where and how they act. Find out what foods, beverages, or over-the-counter medicines will affect your prescriptions.
- Be careful. Self-medication, either by misuse or misinformation, is hazardous. Don't make a decision to stop the long-term use of a drug without medical supervision. Don't take more than the prescription calls for. Avoid combinations of drugs. What you don't know can kill.
- Be aware of your coping habits. Whatever the problem, do you increasingly tend to avoid or solve it with medications?

As Betty Ford has proved, confronting the reality of addiction is the only way to exercise some control over it. Private realities which signal a public danger should stimulate a national awareness, so that stigma may be replaced by strength of purpose. Mrs. Ford's courage in publicly admitting her need for help is an example for all women, as well as for the government and the medical establishment. It liberates us all, and will help to assure more cautious use of all types of drugs in the future. ■

AUTHOR'S NOTE: Muriel Nellis is President of National Research and Communications Associates, Inc., Washington, D.C. and Director, H.E.W. Study on Drugs, Alcohol and Women's Health. She also serves on the Women's Task Panel of the President's Commission on Mental Health.

****DRUG ABUSE WARNING NETWORK SPECIAL REGIONAL REPORT SERIES**********DRUG ABUSE WARNING NETWORK SPECIAL REGIONAL REPORT SERIES****
---PREPARED BY THE INFORMATION RESOURCES UNIT, INFORMATION SYSTEMS SECTION, OFFICE OF COMPLIANCE AND REGULATORY AFFAIRS, DRUG ENFORCEMENT ADMINISTRATION (TELEPHONE (202) 633-1316)

NEW YORK STATE

SMSA NAME: NEW YORK

TABLE A - CONSISTENTLY REPORTING EMERGENCY ROOMS

CSA SCHED	NAME	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
9	ISOSORBIDE DINITRATE	1	0	0	0	1	1	1	0	0	0	0	0	2	1	7
9	CHLORPROPAMIDE	1	1	0	0	0	0	0	2	0	0	1	0	2	0	7
9	CHLORTHALIDONE	2	1	0	0	0	0	0	0	3	0	0	0	1	0	7
SUB-TOTAL FOR: CSA9		1,040	884	779	802	796	746	872	784	924	1,096	869	1,088	995	1,033	12,612
TABLE TOTAL		2,277	2,134	1,882	1,946	2,014	1,848	2,052	1,971	2,142	2,433	2,046	2,497	2,480	2,314	28,004

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCE ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES IT INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST 90% OF THE DAYS INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

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NEW YORK STATE

SMSA NAME: NEW YORK

TABLE A - ALL EMERGENCY ROOMS

CSA SCHED	NAME	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
9	FLUPHENAZINE HCL	20	7	8	8	4	4	8	7	2	13	10	16	12	10	139
9	IMIPRAMINE	6	4	7	4	9	9	14	14	11	14	7	9	12	13	137
9	DOXEPIN	5	10	7	12	4	14	13	12	11	14	4	9	4	5	128
9	LITHIUM CARBONATE	6	6	13	7	8	1	9	9	7	15	8	8	15	13	125
9	BENZTROPINE	19	4	3	4	5	4	6	6	5	14	12	11	11	10	124
9	METHAPYRILENE/SCOPOL	8	5	14	5	8	6	14	7	12	9	5	7	6	8	114
9	DIPHENHYDRAMINE	10	9	6	9	4	10	3	6	8	3	4	5	7	9	93
9	PERPHENAZINE/AMITRPT	10	9	5	3	5	6	1	9	9	5	8	3	9	5	87
9	INSULIN	8	13	3	3	5	0	8	1	5	11	4	6	1	3	61
9	THIOTHIXENE	2	4	5	2	6	1	2	7	4	3	1	3	10	4	54
9	MYTOL	4	2	8	0	6	4	4	1	2	8	2	3	5	4	53
9	PARAQUAT	10	16	2	2	0	1	1	2	1	3	0	0	0	0	46
9	PROPANOLOL HCL	7	5	8	7	1	1	4	3	5	0	1	2	4	3	43
9	METHYLDOPA	3	3	7	5	1	1	2	1	4	1	4	2	5	0	39
9	ERYTHROMYCIN	2	8	4	1	3	2	2	4	4	2	2	1	1	2	38
9	HYDROXYZINE	9	2	2	2	0	4	4	2	1	3	3	2	2	1	37
9	PENICILLINS POTASSIU	9	12	5	0	1	0	0	1	3	3	2	0	0	1	37
9	PERPHENAZINE	3	3	2	1	2	2	4	3	2	1	0	2	6	5	36
9	AMPICILLIN	10	1	3	2	5	3	3	1	1	1	2	1	1	1	35
9	TETRACYCLINE HCL	7	0	2	3	2	2	4	0	1	0	1	1	2	1	34
9	CONTAC	3	2	4	3	1	1	1	0	3	7	7	2	1	2	34
9	MIDOL	3	2	2	2	0	0	1	8	1	4	2	4	0	3	32
9	HYDROCHLOROTHIAZIDE	6	6	2	2	0	3	2	3	2	1	2	0	1	2	32
9	FUROSEMIDE	5	3	1	3	3	0	2	4	2	1	2	3	3	0	32
9	TRIMEXYPHENIDYL HCL	6	1	2	6	1	1	3	3	1	1	1	0	2	3	31
9	ORISTAN	3	2	2	3	1	2	4	0	2	5	3	0	2	2	31
9	INDOMETHACIN	1	2	3	1	0	1	4	2	3	2	0	1	4	1	25
9	DISULFIRAM	4	2	0	3	1	3	0	1	4	3	0	0	1	1	23
9	DIET PILL	1	5	2	0	2	5	2	6	1	2	0	1	2	0	23
9	GLUES	0	0	1	3	2	3	2	2	4	2	1	0	0	3	23
9	PRIMIDONE	2	0	0	2	0	0	2	0	6	4	2	1	2	1	22
9	BORAX	0	0	4	1	2	2	3	0	0	3	3	3	0	1	21
9	ACTIFED	1	2	1	1	0	2	1	4	2	0	3	0	3	1	21
9	DIGOXIN	3	0	2	0	1	2	1	4	1	0	3	2	1	1	21
9	DIMETAPP	2	2	4	2	1	0	2	4	1	1	0	0	0	1	20
9	SEDATIVE MISC	0	0	0	0	0	1	0	0	4	3	5	5	2	0	20
9	CAFFEINE	1	2	0	1	3	1	1	0	1	1	0	2	4	2	19
9	CHLORPHENIRAMINE	2	1	1	0	1	1	1	0	3	3	0	1	1	2	17
9	METHOCARBAMOL	0	1	2	1	0	2	2	0	0	2	1	2	3	0	16
9	PROCHLORPERAZINE	1	4	1	0	1	0	0	2	1	1	2	0	2	1	16
9	DESIPRAMINE	2	0	0	1	1	1	1	0	5	1	1	2	1	0	16

THE SUBSTANCES LISTED UNDER 'CSA-9' SPECIAL CATEGORY INCLUDE ALL DRUGS AND SUBSTANCES NOT CONTROLLED UNDER THE CONTROLLED SUBSTANCE ACT OF 1970. CSA-6 AND CSA-8 REFER TO EXCEPTED OR EXCLUDED DRUG PRODUCTS. WHEN THE TERM 'CONSISTENTLY REPORTING' IS USED IN THESE TABLES IT INDICATES THAT THE FACILITIES HAVE REPORTED AT LEAST 90% OF THE DAYS INCLUDED IN THE TABLE REPORT PERIOD. THE TABLES INCLUDE ALL DRUG MENTIONS REPORTED BY DAWN MEDICAL EXAMINERS AND ALL CSA-I MENTIONS FROM DAWN EMERGENCY ROOMS AND MORE THAN SIX MENTIONS OF ALL OTHER DRUGS AND SUBSTANCES LISTED IN SMSA-LEVEL EMERGENCY ROOM DATA TABLES.

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NEW YORK STATE

SMSA NAME: NEW YORK

TABLE A - ALL EMERGENCY ROOMS

CSA DCMID	NAME'	APR 78	MAY 78	JUN 78	JUL 78	AUG 78	SEP 78	OCT 78	NOV 78	DEC 78	JAN 79	FEB 79	MAR 79	APR 79	MAY 79	TOTAL
9	DIGITALIS	4	6	4	0	0	0	0	0	0	1	0	0	1	0	16
9	METHAPYRILENE HCL	0	0	1	0	1	3	4	1	0	1	2	2	0	1	16
9	ANALGESIC MISC	0	1	1	3	0	0	2	1	2	0	1	2	2	0	15
9	NORGESIC	1	1	0	1	0	3	1	1	1	3	0	0	3	0	15
9	BROMPHENIRAMINE MALE	1	5	2	1	1	0	0	3	2	4	0	0	0	0	14
9	CODEIDIN	1	3	1	0	0	3	1	1	2	0	0	0	1	1	14
9	NITROGLYCERIN	1	2	0	2	0	0	0	1	1	2	2	1	2	0	14
9	FERROUS SULFATE	1	1	0	1	1	2	1	3	0	1	0	3	0	0	14
9	ALCOHOL SUBSTITUTES	0	0	0	0	0	1	2	2	1	1	1	0	2	3	13
9	TRIAMTERENE	2	0	3	0	0	0	0	1	0	4	0	3	0	0	13
9	DIMENHYDRINATE	1	0	1	2	1	2	0	1	0	1	0	2	1	1	13
9	ALLERGY	1	0	4	1	1	1	0	2	2	1	0	0	1	0	12
9	MOTRIN	4	1	1	0	2	0	1	0	0	0	1	1	1	0	12
9	COMBID	3	1	1	0	1	0	0	1	1	0	0	0	2	1	11
9	TRANYLCYPROMINE	1	2	0	1	0	0	0	0	0	1	0	2	1	3	11
9	CEPHALEXIN	1	1	3	0	0	0	0	2	1	0	1	1	1	0	11
9	CARBAMAZEPINE	0	0	1	0	0	0	0	1	0	0	2	1	0	2	11
9	DIURETICS MISC	1	1	1	0	0	0	1	1	0	0	3	1	1	1	10
9	ORAL CONTRACEPTIVE U	4	2	0	0	0	0	0	0	0	0	0	1	0	2	10
9	ERYTHROMYCIN	0	1	0	1	0	0	1	0	0	1	2	2	0	0	9
9	MESORIDAZINE	0	2	0	0	1	3	0	1	0	0	0	0	0	1	9
9	PHENOTHIAZINE	0	0	3	0	0	0	2	0	1	0	1	0	0	1	9
9	NARDIL	0	0	1	0	0	1	2	2	0	0	0	1	0	2	9
9	CHLORPROTHIXENE	0	1	0	0	0	1	0	1	1	0	0	0	3	2	9
9	PROMETHAZINE	2	0	1	1	2	0	0	0	2	1	0	0	0	0	9
9	PREDNISONE	2	0	3	0	0	0	1	0	1	0	1	1	0	0	9
9	VITAMIN MISC	0	0	0	0	0	2	0	0	2	0	0	1	1	1	9
9	WARFARIN SODIUM	1	2	2	0	0	0	0	1	0	0	0	1	1	1	9
9	AMINOPHYLLINE	0	1	0	1	0	1	2	0	1	0	1	0	1	1	9
9	PARAFON	0	0	0	1	1	0	2	0	0	1	0	0	2	1	8
9	ANTIBIOTICS MISC	2	1	0	0	0	0	0	2	0	2	1	0	0	0	8
9	GLYCERYL GUAIACOLATE	0	0	3	0	0	0	2	0	0	0	0	0	0	3	8
9	DOPE	1	0	0	0	1	2	0	0	1	0	1	0	2	2	8
9	PHENYLBUTAZONE	1	1	2	0	0	0	1	0	1	0	1	1	0	0	8
9	CIMETIDINE	1	0	0	0	0	1	0	0	2	1	0	1	0	1	7
9	PHENOXYMETHYLPENICIL	0	1	0	0	0	0	0	0	3	1	0	1	0	1	7
9	SINUTAB	0	1	2	0	1	0	2	0	0	0	0	0	0	1	7
9	BUTYL NITRITE	2	0	0	0	0	0	1	0	0	3	0	1	0	0	7
9	VITAMINS W IRON	0	0	2	1	0	3	1	0	0	0	0	0	0	0	7
9	THEOPHYLLINE	0	0	2	0	1	0	0	0	1	0	0	1	2	0	7
9	CHLORPROPAMIDE	1	1	0	0	0	0	0	2	0	0	1	0	2	0	7

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[The following statements were submitted for the record:]

STATE OF NEW YORK
COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE
PREVENTION AND EDUCATION
Office of Alcoholism and Substance Abuse
EXECUTIVE PARK SOUTH
ALBANY, NEW YORK 12203

ROBERT E. WALLACE
Chairman

STATEMENT OF ROBERT E. WALLACE, CHAIRMAN

I am very pleased to submit this paper in support of House Bill #3916 and appropriate amendments to support the appropriation of sixteen million, one hundred thousand dollars ($16,100,000) for prevention efforts in alcohol and substance abuse control.

As Chairman of the New York State Commission on Alcohol and Substance Abuse Prevention and Education, I congratulate the Congress for providing leadership and support to this very critical area of need. In passing this landmark legislation your sub-committee reinforces what many of us feel, that in times of shrinking resources, "business as usual" can no longer prevail. Your actions show an appreciation of the fact that legislative remedies dictated by crises are neither the best nor the most effective responses to our needs. And it says, in very positive ways, that you understand and support the concepts of prevention. With these concepts in mind, it is now time to get on with what needs to be done.

Were I to express any misgivings at this particular piece of legislation, it is that it is too little, too late. When you realize that New York State alone spends over twenty (20) million dollars itself in prevention, education and early intervention programs, a Federal allocation of sixteen million, one hundred thousand dollars ($16,100,000) is but a drop in the bucket -- barely enough to make but a dent in the problem. What the present appropriation of $16.1 million will do, however, is demonstrate Federal commitment to work on the problems of prevention and to prove that prevention is both cost-effective and efficient.

I very strongly urge you to do whatever you can do to increase the appropriation for prevention both this year and in future years. As the State putting forth the greatest effort in this area, I offer to the Congress an opportunity to review our various programs, to evaluate their effectiveness and to use the programs and services which we provide to the citizens of this State as yardsticks by which prevention and early intervention can be judged. New York State and New York City have the largest history of those communities engaging the forces of drugs and alcohol. As a consequence, we have acquired the richest and most meaningful experiences and we offer them to you and to other communities across the country. We are reassured by the action taken by your sub-committee which for the first time offers some hope before, rather than after, the fact.

BOARD OF EDUCATION
CITY OF NEW YORK
PROJECT 25
Drug Prevention Education Program
of Community School District 25
144-80 Barclay Avenue
Flushing, N.Y. 11355
358-0873

Joan M. Kenny
Community Superintendent

Alice M. Riddell
Director

The Changing Character of Drug and Substance Abuse - The Federal Response

I am submitting testimony today as a person who has been involved with the alcohol, drug and substance abuse problem for fifteen years. I am currently the Director of Project 25, Community School District 25's School-based Drug Prevention Education and Intervention Program (N.Y.C. Board of Education), a position which I have held for ten years. In addition, I am an appointed member of the New York State Advisory Council on Substance Abuse; a member of the Board of Governors and a Trustee of Daytop Village, Inc.; a member of the Queens Borough President's Advisory Council on Alcohol and Substance Abuse. (Resume attached)

In line with the focus of your hearing, I have reviewed my experiences over these past fifteen years. The substance abuse problem has had some changes over years. When I refer to substance abuse I include alcohol, inhalants, marihuana, pills, prescription drugs, narcotics - the entire spectrum. As a junior high school classroom teacher ahd grade advisor fifteen years ago, I was dealing with 7th, 8th, and 9th grade students who were getting high on all of the aforementioned substances.

At the time a few drug-free treatment programs had appeared on the scene to introduce the concept of treatment versus incarceration. Shortly thereafter, a handful of people who were working with teenage and young adult abusers who were not yet hard core addicted, frustrated because of the total absence of services for these individuals and the idea that a person had to go the entire route to full addiction before he or she could qualify for service; along with the increasing awareness that as many clients entered and completed treatment programs, there were countless others awaiting admission; began articulating the need to provide services to persons who were using/abusing drugs but were not yet addicted. This covered a wide spectrum of citizens from the 7th, 8th and 9th grade students smoking pot or indulging in the salad bowl to the adult pill abuser trying to lose weight or alter moods, to the serviceman in Asia exposed to the readily available strong stuff, to the college student caught up in social issues, to the medical and law student who either paid his way through school making, buying and selling drugs or who had the "holier than thou" philosphy of it's OK for me to do it but not for the others, as well as the flower children and street kids trying to deal with or escape from their realities.

Thus, the idea of prevention was born, preventing individuals from becoming addicts.

In order to do this, the helping person had to intervene in the current life style of the user/abuser to affect change in his attitudes and behavior with regard to drugs. In addition, since it was recognized that the drug itself was not the problem but only the symptom of a problem, one had to focus on the "why" of drug abuse. This involved self-exploration of one's values, self-concept and how one made decisions. All drug abusers make a personal, individual decision to use or abuse drugs or substances. He or she is not forced to do it.

Furthermore, in order to reach these clients, to be a catalyst for change, the helper knew that he or she had to educate non-users and abusers to be able to identify signs and symptoms of substance abuse which included pharmacological information, behavioral and attitudinal changes, to educate them with regard to what help was available, to educate them to be able to communicate with and motivate the users and abusers to seek help. This group included parents, teachers, school administrators, employers, peers, governmental and private agencies, professionsals, clergy, unions. It also included students who would receive classroom instruction, didactic information suggested by and included in the required Health Education Curricula.

Finally, the helper recognized the need for communities to face the substance abuse problem rather than hide it, to become aware of the devastating and far-reaching effects of it in their community and to accept and welcome the important services necessary for its residents to cope with their substance abuse. Here we are dealing with the entire community as a social system.

And so we have the three phases of prevention:

1. Prevention in a general sense which involves developing an awareness and understanding of the problem, its effects and its remedies (primary prevention). This may include large group presentations, seminars, public meetings.

2. Education which involves providing didactic information concerning identification signs and symptoms, pharmacology, resources and the acquisition of communication and motivational skills (secondary prevention). This may include workshops, conferences, classroom lessons.

3. Intervention which involves changing the course of behavior and attitude of experimentors, users and abusers who are not yet physically, psychologically or emotionally addicted (tertiary prevention). This may include individual, group and family counseling as well as psychological, educational and vocational testing and counseling.

The frame of reference for prevention as outlined above applies to all target populations. It is most important to point out here that the key to providing intervention services is the process of intake and screening. All persons do not require intervention services. Therefore, specific criteria should be established to identify those in need of various intervention services and the criteria adhered to.

School-based programs in New York City have been providing prevention and intervention services for the past nine years to students in elementary, junior high and high school. These services must be ongoing since drug and alcohol prevention is not accomplished with one prescription - such as: all students in Grade 4 will receive instruction in the use/misuse of drugs and alcohol. Classroom instruction alone concerning pharmacology is not effective in changing patterns of behavior.

It is crucial to understand the concept of developmental tasks to fully comprehend the role of prevention and intervention. In order to reach total maturity as an adult, every individual needs to experience and complete a series of developmental tasks. These tasks can be associated with general age levels, however, since each individual is unique, each one has his own internal schedule. Therefore, schools must provide continuous activities focusing on decision-making, coping skills and values clarification so that students may internalize these learnings and use them when it is applicable for each individual student. For some students, it might be in 6th grade, for others it might be 8th grade and still others may be able to handle the pressures of adolescence until 10th grade when suddenly they feel inadequate, alone, afraid, angry and hostile.

The public school programs in New York City meet these needs by providing a wide range of activities and services. These include human relations classroom lessons, parent workshops, small group assistance, crisis intervention, individual and family assistance, and referral services. These activities vary in focus and intensity according to the client's needs. Thus, a preventive group experience for students at the 6th grade level not yet experimenting with drugs but confused, concerned and apprehensive about entering junior high school, would be very different from an interventive group experience of 8th grade students who are experimenting with and abusing alcohol and drugs. The most intensive service provided in some districts is the Alternate Class School for students who are experimenting with and abusing alcohol and/or drugs where it is beginning to negatively affect their normal progress academically, socially and emotionally. This is an intermediate service before treatment.

The attached flow chart of services will provide a more graphic view of the substance abuse continuum.

SCHOOL SYSTEMS

Requests for Services

Principal
Asst. Prin.
Guidance C.
Teacher
Student
Parents
Court
Community Groups

Prevention Services

Magic Circle
Humanities Educ. Lessons
Faculty Conf.
Teacher Conf.
PTA Meetings
Community Present.
Community Liaison
Classroom Present.
Assemblies

→

Educational Services

Assemblies
Faculty Workshops
In-Service Courses
Parent Workshops
Community Workshops
Health Educ. Curricula

→

Intake & Screening

→

Intervention Services

Crisis Services
Small Group Assistance
Individual Assistance
Family Assistance
Referral:
- Back to Class
- Alternate School
- Mental Health Agency
- Drug Treatment Program
- AA, Alanon, Alateen
- Gamblers Annonymous
- Bureau of Child Welfare
- S.P.C.C.
- Courts

SYSTEMS OTHER THAN SCHOOLS

Requests for Services

Schools
Comm. Organ.
Courts
Prof. Organ.
Business Organ.
Union Organ.
Employers

Prevention Services

Seminars
Comm. Present.
Conferences
Assemblies
Cooperative Prog. i.e. Senior Citizens
Speaking Engagements

→

Educational Services

Workshops
Conferences
Speaking Engagements

→

Intake & Screening

→

Intervention Services

Crisis Services
Small Group Counseling
Individual Counseling
Family Counseling
Referral

→

Treatment

Mental Health Facilities (inc. alcohol program)
AA
Drug Free Program
Methadone Maintenance

One can easily see from the chart that substance abuse services constitute one continuum from the first prevention service to the final treatment service regardless of target population - be it females, adolescents, prescription drug abusers or any other special group. The differentiating factor for each target group would be articulated and identified at the point of intake and screening. Each part is required to attain the whole. One cannot and should not exist without the other.

The third question raised by the committee has to do with if and how prevention and intervention programs can be evaluated and replicated.

Services within programs can be evaluated. Personnel can be evaluated. Consequently, programs can be evaluated. However, programs can not be held responsible for the total substance abuse problem. They cannot be held responsible for people for whom they do not provide services. In order to conduct a comprehensive evaluation a longitudinal study would be required. Nevertheless, there are many instruments and techniques that may be used to measure decreases in substance use and abuse, changes in attitudes, behavior, self-image and decision-making. Measurements may be done to determine responsibilities concerning attendance at work or school, performance, involvement with the law and many other indicators. However, these indices cannot be measured against the entire substance abusing population.

Can successful programs be replicated? Yes, provided that all aspects of the program are replicated. If one attempts to emulate a model program through program activites, goals and objectives without giving consideration to the staff qualifications and patterns, then the program will not be duplicated in outcome and success. My own personal experience has been that a multi-discipline approach is essential to be successful in changing behavior and attitudes. A team approach utilizing rehabilitated persons, teachers, counselors, psycholgists, family and neighborhood workers and various others according to the design of the program does work. The team approach integrated in a comprehensive school-community program is the ultimate in the continiuum of services.

How has the character of substance abuse changed? Basically the changes have taken place in two areas. First is the changes which have taken place within families. Today, more parents than ever are abusing substances and are turning on their own children to drugs and alcohol. The increase in divorces has created situations of confusion, helplessness, fear, dual parenting, effecting all members of the family frequently resulting in substance abuse as an escape.

The second has to do with the changes in the agencies and institutions charged with funding, monitoring and evaluating programs, developing five year comprehensive plans, collecting and distributing data to provide current information to providers and consumers. The constant reorganization of the agencies, turnover of top level administrators, unqualified or limited qualified administrators has resulted in insufficient funding levels, gaps in services, a constant re-invention of the wheel, changing definitions, guidelines and criteria, competition and confusion among programs and between prevention and treatment, between alcohol and drug programs rather than a comprehensive network system.

Despite this or in spite of this, meaningful services are being provided in New York State daily with success. In fact, a statewide network has developed out of mutual needs, concerns and endeavors which includes representation of all programs in the continuum. The New York Urban Coalition has been the conduit in this effort.

New York State and New York City in particular, has been a leader in the fight against substance abuse for many years through state funding. For some reason however the federal government avoids using the city and state as a resource. Therefore, the federal response should be:

1. Set substance abuse as a priority and appropriate funds accordingly.

2. Bring federal definitions, guidelines and criteria for funding in line with reality where the institution and agency function as a support for service delivery rather than an impeder. For example, current definitions for prevention focus on primary prevention only. Methadone maintenance program funding frequently results in counter-therapeutic treatment for clients.

3. Utilize experienced programs and localities as research and resource banks.

Proportionately, over the years, very little federal money for drug prevention and treatment have been allocated to New York. Frequently, we find programs cited as models in other parts of the country where we have been doing the identical practice for several years.

If there are any questions concerning my statements, please feel free to contact me.

[Whereupon, at 1:05 p.m., the subcommittee adjourned, to reconvene at the call of the Chair.]

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